Safe with us vs the *sacred trust.*
Policy Change Under Conservative Government:
Health policy under Britain's Thatcher and Canada's Mulroney.

by

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CONTENTS

I made a pledge with myself long before I ever sat in this House in the years when I knew something about what it meant to get health services when you didn't have any money to pay for it. I made a pledge with myself that some day, if I ever had to anything to do with it, people would be able to get health services, just as they are able to get educational services, as an inalienable right of being a citizen of a Christian country.

Premier Tommy C. Douglas,
Debates of the legislative assembly of Saskatchewan, 1 April 1954.

No society can call itself civilised if a sick person is denied aid because of lack of means.

Society becomes more wholesome, more serene, and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves, but also their fellows, have access, when ill, to the best that medical care can provide.

Aneurin Bevan,
from Michael Foot,
Aneurin Bevan Vol 2 1945-1960.

Acknowlegdements and Dedication

Then I got down to writing, and it was awful. I don't know why anyone would want to do it. It stinks. It's like a disease. It's an illness, writing. It steals your body from you. There's no audience. You're alone.

Spalding Gray,
Monster in a Box.

My first words of thanks go to Dr Roger Duclaud-Williams. Roger took over the thesis following Jeremy's illness at what was its most critical phase, and directed it through its rewrites too numerous to count. Through it all Roger remained patient and attentive while I grew increasingly impatient and inattentive. It is largely thanks to his concern for the quality of the final product - in spite of my general mood - that this thesis saw its end.

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In the end I think this thesis in one which both my supervisors can be proud of and I thank them both for their contribution to this work.

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DECLARATION OF PREVIOUSLY USED MATERIAL

Material contained in this thesis has been extracted in whole or in part from the following:

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Finally, material in this thesis was written during my term as a visiting student at the Carleton University School of Public Administration, January 1996 to August 1996 as part of the following graduate seminars: Health Policy (50-573W); Interest Groups and Social Movements (50-573U) and; Policy Making (50-568).

Michael A. O'Neill,
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ABSTRACT

This research explores the link between New Right ideology and the making of public policy. Taking the Thatcher and Mulroney Governments as examples of the New Right in government this research considers the areas of policy convergence and divergence between them using health as a case study. This study concludes that these 1990s variants of Conservativism differed both in terms of their rhetoric and their ability to chart new public policies. This study finds that the Thatcher Government was a more effective agent of change than the Mulroney Government with institutional differences as the main explanatory variable. Other research themes raised in this research include: The applicability of the incremental policy making model to the study of Canadian and British health policies; the role of interest groups in the development of health policies; and the thesis of the irreversibility of the welfare state. It was found that the incremental model could not account for the rapid and large changes in British health policy but could serve as a theoretical framework to explain health policy developments in Canada. Interest groups for their part were found to have reacted in differing ways to the challenges posed to them by New Right government, seeking to form advocacy coalitions in Canada while remaining resolutely independent in Britain. Finally, this research concludes that the irreversibility of the welfare state thesis as presented by Therborn and Roebroek remains valid, that is that the political popularity of national health insurance continue to isolate this sector of social policy from dramatic rollback.

LIST OF ABBREVIATIONS

AHA:	Area Health Authority
BCNI:	Business Council on National Issues
BMA:	British Medical Association
BNA:	*British North America Act* (Constitution Act 1867)
CCC:	Canadian Chamber of Commerce
CMJ:	British Medical Journal
CHA:	Canadian Hospital Association
CHC:	Canadian Health Coalition
CMA:	Canadian Medical Association
CNA:	Canadian Nurses Association
CMAJ:	Canadian Medical Association Journal
COHSE:	Confederation of Health Service Employees
CPRS:	Central Policy Review Staff
DHSS:	Department of Health and Social Security
DoH:	Department of Health
EPF:	Established Program Financing
FPC:	Family Practitioner Community
FTA:	Canada-United States Free Trade Agreement
GDP:	Gross Domestic Product
GNP:	Gross National Product
HAT:	Housing Action Trusts
HCHS:	Hospital and Community Health Services
HEAL:	Health Action Lobby

HIDS:	*Hospital and Diagnostic Services Act*
HMO:	Health Maintenance Organization
HWC:	Health and Welfare Canada
IM:	Internal Market
NDP:	New Democratic Party
NHS:	National Health Service
NI:	National Insurance
OAS:	Old Age Security (also referred to as Old Age Pensions)
RCN:	Royal College of Nursing
RHA:	Regional Health Authority
RTB:	Right to Buy
TUC:	Trade Unions Congress
UIC:	Unemployment Insurance Commission (acronym commonly refers to the unemployment benefit)

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PART I, CHAPTER ONE:

INTRODUCTION

1.0 Introductory comments

"Why health care?", I have often been asked by friends, family and acquaintances in the course of this research. Why indeed. This research is not about health care *per se* but about the change in public policy brought about by a shift in the prevailing political and economic orthodoxies which guided the public policies of the British and Canadian governments, and indeed most western governments, in the Post-War period. This thesis is also about the welfare state and its crisis, insofar as health is seen as one of its core elements. This link between health and the greater welfare state is particularly relevant here since in both Canada and Britain health care is the only programme to serve the entirety of the population throughout their lives. Finally, this thesis is also about change, in particular how institutions facilitate or block it.

The choice of health care as a case study and the concentration on the 1980s period arises out of both personal and research experience. In Canada, 1984 marked the end of the Trudeau era and the beginning of another, the Mulroney era. From 1984 onwards it appeared that ideas converged between the residents of 1600 Pennsylvania Avenue, 10 Downing Street and 24 Sussex Drive. This was particularly evident in Canada-US relations, where the acrimony of the Trudeau-Reagan relationship was replaced by the "Shamrock Summit" between Mulroney and Reagan (see Doern and

Tomlin, 1991). Beyond their friendlier relations all three governments described the problems of government in common terms which included a fixation with inflation, national debts and public deficits at the centre of their rhetoric and policies (see Savoie, 1994). How these common concerns impacted on real policies is one of the questions considered here.

My interest in health care also stems from the place it has occupied in the 'collective unconscious' of the welfare state. In both Canada and Britain the public health care system is sometimes viewed as a defining characteristic of the society. Especially in Canada, Medicare is symbolic of the kinder and gentler approach which distinguishes Canada from its southern neighbour. Thus, it appeared the health system would be the perfect vehicle to examine the changes in public policy brought forward by the New Right.[1]

A final note - this thesis also springs out of my personal convictions about the right of all people to health services. While often portrayed as an economic or political issue, for example in the debate concerning funding (*over* or *under*), it is my belief that health, as well as many other elements of the welfare state, should only be discussed as issues of social justice. Thus I reveal my bias. From my perspective one should be wary of the economic justifications provided by the New Right regarding the future of social welfare. While I have tried to be dispassionate and objective about the cases under study I make no claim to having completely divorced my bias from this research or its conclusions. However, strict methodology was employed to ensure that this work would stand as a proper enquiry in political science. I can only hope the readers agree.

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[1] There are two main streams in the New Right (also termed in the literature as neoconservatism or neoliberalism) evident in the 1980s and 1990s. For the purposes of this study I am primarily concerned with the economically liberal stream of neoconservatism rather than the primarily American stream which involved a large moral/religious component and some authoritarian elements.

1.1 Theoretical and research themes

This thesis is not primarily concerned with theory building, although it finds its relevance within the theoretical framework of comparative history (see Castles, 1989) and historical institutionalism (see Thelen and Steinmo, 1992). These frameworks were chosen because of the middle ground they offer between theory and description thereby permitting the textualization and contextualization of the events which marked the policies of the New Right in government. My research focus is thus primarily concerned with deriving the causes of policy change from the context within which it has occurred. In this instance the context is largely ascribed to the institutional distinctiveness (and similarities) of Canada and Great Britain. This approach also permits a more empirically and theoretically catholic approach to the events which marked the Thatcher and Mulroney governments. This is particularly important as my goal is not to build a grand theory of policy change.

Six major themes will be considered in this study. The first concerns the nature of the New Right public policy. According to several authors (Alaszewski and Manthorpe, 1990; Banting, 1991; Banting, 1992; Barry, 1987; Bosanquet, 1983; Flynn, 1989; Gamble, 1988; Green, 1987; Hudson, 1989; Hudson, 1990; King, 1988; Mishra, 1990) there are three main elements to the New Right's political programme: Private rather than state provision of services, including social services such as health; needs-based targeting of social provision; and an intention to control overall public expenditure, notwithstanding the increased spending in certain areas such as defence and law and order. In Britain, the pursuit of these policies has been described with the term 'revolution.' This revolutionary fervour differentiates the Canadian variant of the New Right from its British counterpart as the Canadian Conservatives did not share the

intensity of purpose and ideological purity which marked the Thatcher government. Thus, "no-one (sic) in Canada refers to a 'Mulroney revolution' comparable to the Reagan or Thatcher administrations" (Banting, 1992, p. 157). The differences between the Canadian and British New Right, and why these differed, will therefore be examined below. How the New Right's form of conservatism marked a change or a break with the traditional nature and ideology of Canadian and British conservatism is the second of the research themes discussed below. This question is linked to the institutional framework of this study but is also derived from some of the literature on Canadian and British party politics (Behrens, 1980; Brodie and Jenson, 1980 and 1990; Gamble, 1988; Green, 1987; Perlin, 1985). Examined below is the dual issue of how the New Right marked a departure from traditional conservatism in Canada and Britain.

The third theme explored below relates more explicitly to the methods of comparative history of public policy and institutionalism. While the ideology of the New Right may be said to have affected the course of social policy in Canada and Britain, these policy changes were channelled through and implemented by state institutions. It is at the institutional level that some of the most interesting points of convergence and divergence between the two cases appear, particularly with regards to the financing of the health system.

The theme of institutionalism is considered here by drawing particularly from Hall (1986 and 1992), Immergut (1992a and 1992b) and King (1992 and 1988). Common to all of these authors is the centrality of the electoral, legislative and executive institutions in their studies. According to this approach, "political struggles 'are mediated by the institutional setting in which [they] take place'" (Thelen and Steinmo, 1992, p. 2, citing Ikenberry). As understood and applied here institutions are "the formal rules,

compliance procedures, and standard operating practices that structure the relationship between individuals in various units of polity and economy" (Hall, 1986, p. 19). Institutions, in short, both obstruct and facilitate policy change. However, rather than consider Ikenberry's "political struggle" as involving only Hall's "individuals," I prefer to speak of 'actors,' thereby allowing for groups and political parties as well as individuals.

It will be argued that the British government used to its advantage a wide range of institutional tools in its successive reforms of the National Health Service (NHS) culminating with the implementation of the internal market in 1990. On the other hand it will be shown that the Mulroney government, with a more limited choice of policy tools, used the fiscal[2] lever to a greater effect than the Thatcher Tories, leading to significant divergence between them. This divergence will be used to illustrate one of the paradoxes of New Right government in Britain as opposed to Canada. Thus, unlike Riker (1969, pp. 146, 141-142, 136), who considers federalism to be a fiction - that is that federal systems do not differ from unitary ones in terms of their policy outputs - part of the argument presented below will be that federalism not only exists, it also matters.

Although it is my contention here that an institutional approach is best adapted to the study of health policy making in Canada and Britain I am aware of the pitfall of 'concept stretching.' As Thelen and Steinmo (1992) note, "institutions constrain and refract politics but they are never the sole 'cause' of outcomes" (p. 3). Moreover, a too focused reliance on the institutional approach "may explain everything until it explains nothing"[3] (Thelen and Steinmo, 1992, p. 5). For these reasons the following discussion will also inform itself from other approaches where germane.

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[2] The term fiscal is one which has many uses in the political and economic literature. For the purposes of my discussion the term should be understood to mean "having to do with the funds and financial affairs of a government, institution, or corporation" (Gage Canadian Dictionary, 1982).

[3] I note in passing that these dangers lay behind most approaches and not institutionalism alone.

Hall (1992) breaks down his analysis into three levels of institutions. The first level, and most basic level, is that of liberal democracy and capitalism; the second that of the organization of socio-political and economic activity, such as the presence of trade-unions and the concentration of capital, the nature of the political system and the structure of government; and the third that of the "routines" and "standard operating procedures" of government agencies and organizations. Some of these "routines," Hall notes, may be informal, although their net effect may be just as important to the process of policy change as more formal mechanisms (Hall, 1992, p. 97).

Immergut (1992a) offers a conception of institutions as providing the "rules of the game," that is, the conduits through which policies must pass. Along the way policies can be blocked, *vetoed*, by actors benefiting from a particular position or status, but only insofar as the rules permit them to. Therefore, behind any policy exists not one single political decision but rather a series of individual decisions which, only when taken together, create a policy. These "veto points" are dependent on the legislative regime, the need to accommodate certain groups or enlist their participation or any other number of conditions. Each of Hall's levels of institutional analysis can be seen either as a veto point or where one resides. However, in order to make full use of Hall and Immergut it is perhaps necessary to view the institutionalist approach as requiring 'institutional stacking.' The lowest level of analysis proposed by Hall, the existence of liberal democratic and capitalist regimes, tells us very little in itself, but is useful as the base upon which other more relevant institutions are dependent for their existence (or to use my terminology, 'stacked'). How influential the subsequent layers of institutions are to the process of policy change is dependent on how solid is their base.

Fourthly, as health is seen here as a central element of the welfare state consideration will also be given to the thesis of welfare state irreversibility put forward by Therborn and Roebroek (1986). One of the threads which will run through my discussion of the impact of the New Right concerns the lack of evidence for a sizeable rollback in the area of health care.

The irreversibility thesis was first advanced as a critique of what Therborn and Roebroek termed the "ideological fad" of the welfare state crisis and as a framework for charting the welfare state's future development. The irreversibility thesis argues that the welfare state is an entrenched part of western liberal democracy and cannot be rolled back simply due to the size of the population it serves and its high level of public acceptance and support (Therborn and Roebroek, 1986, p. 332; Mishra, 1990). While it is my contention that the thesis of irreversibility applies to the case of health care, other aspects of the welfare state may be susceptible to rollback.

Central to Therborn and Roebroek's analysis is institutional form (or model) taken by the welfare state.[4] Esping-Andersen (1990a and 1990b) divides the capitalist West into three types of welfare state regimes: "liberal," "corporatist-statist," and "social democratic" (universalist) (1990a, pp. 111-112) with Canada and the United Kingdom part of the liberal cluster of welfare state regimes, a cluster where "means-tested, modest universal transfers, or modest social insurance plans predominate" (1990a, p. 111). However, Therborn and Roebroek's thesis implies that the welfare state is irreversible only where there is universal benefit to citizens underpinning universal acceptance and, thus, support for the welfare state through democratic institutions. At first glance, the liberal model as described by Esping-Andersen does not provide the required coalition of

[4] Esping-Andersen prefers to refer to regimes rather than models. In terms of this discussion the terms are considered as synonymous.

support for welfare state institutions. However, in both Canada and Britain, while the overall welfare state models conform to the liberal model, the provision of health care in both countries diverges from the liberal model and is more akin to the social democratic regime model (Esping-Andersen, 1990a, p. 112; see also Tuohy, 1993; Hill, 1993). In short, as a universal social entitlement, health care benefits from a wide "supportive consensus" (Key, 1964) and is thus sustained by the liberal democratic system.

Finally, two models of the policy making process will be discussed as part of my analysis - incremental policy making and interest groups politics.

The incrementalist literature (principally Lindblom, 1958 and 1979; Weiss and Woodhouse, 1992; Wildavsky 1964; Dempster and Wildavsky, 1979) tends to portray the policy making process as one which is slow and laborious, best summarized by Lindblom's reference to "muddling through." It will be argued below that while the developments in Canadian health policy have been consistent with the incrementalist model of policy making this model cannot account for the radical policy changes which occurred in the Britain's health system, particularly after 1983. This divergence will be partly explained by differences in the policy tools available to each government, policy tools which are dependent on the institutional structures of the state.

Incrementalist analysis can take three forms: "Simple incremental analysis," where analysis is "limited to consideration of alternative policies all of which are only incrementally different from the status quo"; "disjointed incrementalism," where analysis takes in a mutually supporting set of stratagems of which simple incremental analysis is one; and "strategic analysis," which is a short cut through "conventionally comprehensive 'scientific analysis'" (Lindblom, 1979, pp. 517-518). It is on the simple incremental analysis model that I will concentrate my discussion as it is this model which "clearly

does lend itself to political incrementalism" (Weiss and Woodhouse, 1992, p. 257). Political incrementalism has itself become synonymous with a small steps approach to policy making as, for example, in the budgetary process (Weiss and Woodhouse, 1992, p. 256), analysis of which is primarily associated with Wildavsky (1964).

Since national health policies are primarily concerned with resources as determined by budgetary allocation - more so under New Right governments committed to public expenditure control - it is difficult to discuss incrementalism without a consideration of government budgetary policies. According to Wildavsky the process of budgetary planning rarely involves an agency's whole budget being re-evaluated every year (Dempster and Wildavsky, 1979, p. 372, citing Wildavsky). In this sense it is possible to see successive changes to the financing of the NHS and Medicare, for example the changes in the prescription charge, as part of a larger process of increasing or decreasing line items "within a narrow range" (Dempster and Wildavsky, 1979, p. 372, citing Wildavsky). However, as noted, the successive reforms instituted by the Thatcher government between 1979 and 1990 raise significant questions about incrementalism utility as a tool for policy analysis. As a result I will propose below "punctuated equilibria" (Eldredge and Gould, 1972) as an alternative to the incremental model.

Much research in health politics has focused on the participation of interest groups[5] and in particular the medical profession, in the health policy development process (Alford, 1975; Coburn, 1983; Day and Klein, 1992; Eckstein, 1960; Freidson, 1975 and 1970; Fulton and Stanbury, 1985; Ginzberg, 1990; Immergut 1992a and 1992b; Taylor, 1960 and 1987; Tuohy, 1988; Wilsford, 1991). Although this tradition is useful in background to the policies pursued in the 1980s and 1990s, institutional structures were

[5] For the purposes of this discussion the groups discussed below are those concerned exclusively with or having a clear stake in the health system.

found to be a greater determinant to policy outputs than interest group activity. This primacy of institutional arrangements over interest group politics is best summarized by Immergut, who notes, "interest groups are embedded with these political institutions, and the scope of interest-group (sic) influence depends upon the logic of these political institutions" (1992a, p. 5). The discussion of interest group politics will concern primarily the existence or absence of interest group coalition and interest group participation to the policy process. In Canada, unlike Britain, the 1980s and 1990s saw the development of coalitions of health sector interest groups.[6] My purpose here will be to describe the process of interest groups coming together in support of a particular policy outcome and posit some reasons why these coalitions formed in Canada but not in Britain. Two different types of coalitions will be discussed below, trade union dominated and professional/stakeholder dominated.

Health politics is often described as marked by the ascendance and dominance of interest groups. Many of the theoretical contributions in the field in recent years concern this issue, most often through the use of either the policy communities or policy networks models (see for example Boase, 1994; Wistow, 1992a). However, these approaches are increasingly being challenged. Dowding (1995), for example, notes that the policy network/community approach is locked in demonstrating general features of the policy environment rather than highlighting a particular cause for policy change. In short, policy networks/communities cannot be seen as independent variables, for they are not only part of the reason for change, but also one of its characteristics (Dowding, 1995, p.

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[6] Some may be tempted to define these as advocacy coalitions although strictly speaking they do not conform to Sabatier's definition: "Actors from many public and private organizations at all levels of government who share a set of basic beliefs (policy goals plus causal and other perceptions) and who seek to manipulate the rules of various governmental institutions to achieve those goals [...]" (Sabatier (1991, p. 151).

137). As does Dowding, I do not seek to deny the importance and influence of interest groups and policy networks in the health sector. Nor is it my intention below to infirm the underlying hypothesis of either of these approaches. However, the picture which will be developed below is of the limited relevance of single interest groups to the development of health policies under Mulroney and Thatcher. The reasons for this are found to be primarily institutional in nature, but also derive from the propensity of the New Right to fear consultation and involvement by non-governmental interests. This was particularly the case of the Thatcher government. As Döhler (1991) notes, one cannot divorce where interest groups are active from how successful their activities will be. More generally, the period of New Right government in Canada and Britain saw policy making become more centralized rather than being "parcelled out" (Pross, 1986).

For the purposes of this study I shall discuss the financing and organization of the publicly funded health systems of Canada (Medicare) and Britain (the National Health Service or NHS). Throughout this research it will be understood that health is dealt with by governments largely as a resource issue. This point is made clearly by Opit (cited in Palmer and Short, 1989, p. 26),

> There is not, nor has there ever been, any real health policy in Australia since federation. There have been various policies about paying for medical and hospital treatment or about how to collect the money or how to distribute it, but even that has been mostly confused and dishonest.

This comment, I believe, describes quite accurately the terrain which I cover below.[7] Thus, when as political scientists we write about health care or health policy we are writing about a system rather than a 'status.' The aim of all health systems is to provide

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[7] To be exact both the Canadian and British governments have made some efforts towards establishing wider health goals for their populations (for example see HWC, 1974 and 1986; DHSS, 1987). However, on the whole the policies which concerned policy makers most during this period focused on the financial and administrative.

health services which will (but often do not) enhance health status. Contained in the above is a profound question for policy makers about what level of financial resources will ensure the health status of the population. This is a complex issue, the political science equivalent of quick sand, which I have chosen to walk around as best I could. Thus, throughout this dissertation I will refer exclusively (useless otherwise noted) to health as a 'system,' funded in whole or in part by the state, what Roemer (1991) terms systems of health insurance.

1.2 Literature reviews

There is quite a large literature available for research in the area of health policy, encompassing a variety of disciplines in the social sciences. As this dissertation's primary aim is to build upon existing work rather than chart new theoretical ground, the literature discussed below should be seen as my primary research tool. However, some limitations to existing theory are identified and discussed in the conclusion. In the following pages I have grouped the literature in terms of its main focus and how it found a place in my study.

1.2.1 Health

The health politics literature is divided into two main types: Firstly, relating to the politics of the health system and; secondly, focusing on policy and systems. However, these categories are not air tight and much overlap exists between them. Very little of this literature is comparative, particularly in the case of the Canada-United Kingdom comparison which is where this study makes its most direct contribution to political studies.

The literature on the politics of health focuses primarily on health as a governmental programme, its development and, as in Britain, its reform. This literature contains at its core the basic themes of political science, such as the influence of power, ideology, interest groups, the political system and institutions, political economy, etc. Unfortunately, much of this literature is single system focused.

The British literature can be divided into two categories: a literature concerning the development and politics of the NHS and, secondly, a literature concerning the developments of the Thatcher government as a starting point for a new examination of the NHS. The principal work in this first category is Rudolf Klein's (1995) *The New Politics of the NHS*. In it, he describes the politics which contributed to the creation of the NHS. Klein goes to the roots of the NHS in 1939 and moves his discussion through to the late 1990s. One of the main themes underlying Klein's work is the interplay which exists between the medical profession and the Government and how this interplay has shaped the NHS as it now exists. His interest in the state-medical profession relationship is also evident in another study (Day and Klein, 1992).

Other contributions to the literature which take into consideration the politics of the creation, development and operation of the NHS include Ham (1992) and Allsop (1995). Both cover more extensively than Klein the developments leading up to and past the creation of the internal market and its aftermath, thus making them part of the second 'wave' of writings on the NHS. Ham and Allsop provide more catholic accounts of health policy than Klein and can be seen more truly as works on health 'policy' rather than 'politics.'

Klein's book also contributes to this second wave of writing on the NHS where he takes his primarily medical profession focused study into the discussions concerning the

reforms outlined in *Working for Patients*. Other works also concerned with the interest group aspect of the internal market are Butler (1993) and Harrison and Pollitt (1994). The former, like Klein, is more formally concerned with the medical profession while the latter treats the issue of professional involvement more broadly to include administrators, managers and other health workers. Studies focusing primarily on the Thatcher government and its ideology and agenda include Renade and Haywood (1991), Griggs (1991), and Wistow (1992a).

Other works on the British health system concentrate on interest group politics. Thus beginning with Eckstein (1960), which stands as the classic study of the British Medical Association (BMA), through Wistow's (1992b) policy communities approach and North's (1995) follow-up work using Alford's (1975) framework, the interest group approach has coloured much research in this area.

Insofar as much of it is focused on interest group politics the Canadian health politics literature mirrors that of Britain. Thus beginning with Taylor's (1960) article on the Canadian Medical Association (CMA) and more directly Coburn (1983), Fulton and Stanbury (1985), and Boase (1994), the interest group approach has continued to infuse Canadian political science research. Even studies such as Barker's (1989) article on cabinet decision making or Tuohy's (1988) article on the extra-billing issue have a physician centred approach.

Canadian political writings about the health system and its development also mirrors that found in Britain. Thus Klein's work is analogous to Malcolm G. Taylor's (1987) seminal *Health Insurance and Canadian Public Policy*. Taylor's work has since formed the foundation of most other works on the politics of the development of Canada's Medicare and is echoed in pieces such as Weller and Manga (1983). Like Klein, Taylor

largely describes the politics of creation as revolving largely around the doctor-state relationship.

Unlike the UK, Canada does not as yet have a very developed literature concerning reform of the health care system - especially as there have been no national reforms of Medicare to match those brought in by the Thatcher government. As a consequence the literature on the reform of the health system is rather sparse. Among those who have attempted to consider this issue have been Swartz (1993) and Burke and Stevenson (1994).

The Canadian-UK comparative literature in the area of health politics mostly treats Canada and Britain as part of wider cross-national studies (Sakala, 1990; Weller, 1983; OECD, 1995). Sakala's work is exemplary of the comparative approach. Her article examines the common patterns in the development of the Canadian and British health care systems to see this provide lessons for analysis of US health care policy. The sources for much of Sakala's discussion centre around the type of literature exemplified in Taylor (1987) and Klein (1995). Weller's article for its part again returns to the role of physicians in policy development.

What is evident from this review is the prevalence of research concerning the role of the medical profession in the study of health politics. The literature noted above was extensively utilized through this dissertation, and augmented by several other primary and secondary sources. However, while interest groups have undeniably played a part in the policies pursued by the Mulroney and Thatcher governments, other more salient factors were identified, particularly institutional and party political distinctions.

The second category of literature is that concerned with the politics of administration of the health system rather than informing research about the wider issues underlying reform. This literature is of two main types; descriptive and prescriptive.

The descriptive literature includes works such as Ham (1992), Allsop (1995), Soderstrom (1978) and Roemer's (1991) mammoth accounting of the world's health systems. These works primarily describe the administrative and operational aspects of the provision of health care. Although, Ham and Allsop also devote some space to a discussion of the politics of health care.

The prescriptive literature is often the most interesting as its point of departure is either a recent reform of the health care system or the author's concern with the need for reform. The British literature ranges from Enthoven's (1985) work on the NHS, which is reputed to be the intellectual origin of the internal market, to Renade's (1995) *A Future for the NHS?*, which takes as its point of departure these same internal market reforms ascribed to Enthoven's monograph.

Much of the literature on system reform has focused on the delivery of services. Articles by Hudson (1992) and Klein (1994) have dealt with issues such as rationing care and service provision which have clear political ramifications for the policy maker.

The Canadian prescriptive literature is best exemplified by the contributions of Rachlis and Kushner (1989 and 1994) where the authors set out what they believe to be the successes and failings of the Canadian health system and propose their own version of system reform. In this instance the authors propose a focus on preventive medicine rather than "illness" insurance. A collection of essays by some of Canada's leading social scientists considers this same theme in Deber and Thompson's (1992) *Restructuring Canada's Health Services System.* This collection is largely concerned with the main

economic issues which the health system faces and how these might be alleviated. This literature is best exemplified by Evans' (1993) piece, *Health Care: The Issue from Hell* which brings home the political difficulties inherent in reforming a cherished - and expensive - part of public policy.

Once again, the Canada-UK comparative literature is quite limited. A collection of essays (Lee, 1994) concerning the existing and future prospects for the British and Canadian health systems broadly discusses issues germane to both, although only a minority of the essays are comparative (Hoffmeyer and Lloyd, 1994; Rathwell, 1994). Also interested in evaluating the performance of the British and Canadian health system on an operational scale is Grogan (1992). This article concerns mostly the institutional differences between different health systems, as well as the political structures, as a means of evaluating their ultimate performance.

As was the case with the literature noted above this literature has provided some of the building blocks for the following study. This study benefited from the analysis which many of these works have set out in support of their alternatives and, as is the case with Enthoven's (1985), as they appeared in subsequent policy.

1.2.2 The Welfare State: Literature review

A related literature to that described above concerns the welfare state and its crisis. In relation to this study this literature is divided into two main categories, that concerned with models of social welfare and policy and that concerned with the crisis of the welfare state.

The literature in this category is primarily concerned with describing the development and operation of the social welfare system. Thus, very much like the

literature noted above, the primary focus here is on actors and political circumstances that have shaped the welfare state as it exists today. Related to this concern with actors and events is the identification of the social welfare system with a particular model or models. This last element is particularly common in the comparative literature, of which very little concerns the Canadian and British cases in particular.

British works representative of the first type of social policy writing are Hill (1993) and Glennerster (1995). Both works are primarily interested in a historical accounting of the period of development of the British welfare state - Hill's being more focused on ideologies and regimes while Glennerster prefers to arrange his discussion thematically according to the shifting political winds in the Post-War period.

The Canadian literature is best exemplified by the work of Tuohy (1993). This account resembles the work of Hill and Glennerster in that it traces the development of the welfare state from its origins, dealing with the political issues in their historical context.

It is in the comparative literature that the issue of the models of the welfare state becomes the greatest focus. This more theoretical approach to the welfare state is best exemplified by the work of Esping-Andersen (1990a and 1990b), which is primarily concerned with "specifying the salient characteristics of welfare states" (1990a, p. 92). Thus, it is to Esping-Andersen's model that this research owes its typology of the British and Canadian welfare states.

This literature finds its relevance in situating the case of health within the wider area of social policy. The linkages between health care and the rest of the social welfare system is clearly shown by these and other authors. Moreover, an intellectual or ideological link exists between health and other areas of social policy, as noted by

Immergut (1992a, pp. 1-3). Thus while the NHS, for example, may be the most visible part of the social welfare menu, it is often legitimized along the same lines as other programmes, especially in discussions concerning its funding. This linkage will be established in the opening segments of the Canadian and British sections.

As this study concerns the impact of the New Right on social policy development I refer to the literature on the adaptation of the welfare state to the changes in the global political economy in the 1970s and 1980s, the so-called crisis of the welfare state. This literature tends to lump most of the Western industrialized states together and to consider the policy limitations posed to governments after the 1970s global economic downturn. Exemplifying this approach is Gourevitch (1986) and a collection edited by Damgaard et al. (1989). Both cover a similar group of countries and share general conclusions. Thus, both argue that the crisis has limited the range of policy options available to governments and they describe how this has occurred in practice. Moran (1988) for his part reviews the literature on the crisis and finds three differing conceptions of it. In addition he points to a distinction between the crisis as one both of citizenship and of the capacity of the state to provide welfare. One must add in closing the contributions of Mishra (1984 and 1990) who explores both the nature of the crisis and how it has been portrayed in the New Right challenge to the welfare state. Mishra's conclusions on this score seem to point to a shift in the public thinking towards the extremes of the spectrum and thus points to possible successes of a New Right rollback.

The literature on the crisis is useful to this study as it is largely within it that the New Right critique exemplified by the Thatcher and Mulroney governments finds its roots. However, while the crisis may have opened the doors of government to the New

Right it is another issue to see if this had any tangible effect on policy, as will be discussed below.

The Canadian literature on the crisis and the New Right includes contributions by Banting (1991 and 1992), Evans (1994) Lightman and Irving (1991) and Tuohy (1993). This literature largely ascribes to Canadian Tories a number of successes in stemming the growth of the welfare state and, in some cases, actual rollback. Interestingly, little of this literature concerns the health system - instead the authors focus on transfer payments to individuals such as pensions.

Banting's contribution suggests the possibility that the Mulroney government's policies were characterized by a recourse to the "politics of stealth," that is where the 'negative' repercussions of programme changes are not immediately perceptible, and secondly, will only emerge over time. This theme is also implicit in Evans (1994) and Lightman and Irving (1991). All five authors seem to predict a difficult future for Canada's social programmes as a result of the policies of the Mulroney government and its legacy.

The British literature for its part also ascribes to the Thatcher Tories an agenda of rollback. Health and social security emerge relatively unscathed the literature argues while education and housing have faced radical change. Among the contributors to this discussion are Flynn (1989), Hudson (1989, 1990), King (1988), and Pierson (1993). Flynn and Hudson proceed by examining the nature of the New Right policy challenge before looking at the New Right's record in policy development. Pierson, who describes the period of the Thatcher government as the most decisive break with the past (p. 246), also runs through the various policy changes over the 1979-1990 period. King's contribution concerns the political theory underlying studies of the New Right and its

effect on the welfare state, and concludes that research to date would have benefited from tighter descriptions of what was understood as the New Right and the welfare state.

With the exception of the piece by King, all the above noted authors provide one part of the larger construction that is the description of the impact of the New Right in government and, as such, they find a place in the development of the argument below. It is particularly interesting that most of these have not paid particular attention to the case of health care in their determinations of the impact made by the Thatcher and Mulroney governments. These writers' particular focus on the intellectual foundations of the New Right challenge to the Beveridge-Keynes model is most relevant to this study.

But was there a crisis of the welfare state? Certainly the economic turmoil caused by the oil shock and since had an intellectual spin-off. This is particularly the case in the United States where Murray (1984), among others, began to question the costs and effects of Post-New Deal social policy (see also Pierson, 1994). The welfare state and the Keynesian model of economic management are inextricably linked with the crisis of the latter becoming or causing the crisis in the former. This joint crisis overlaid a more fundamental change in the international economic system with the globalization not only of markets, but also of sites of production and labour (Michalet, 1985; Lipietz, 1983). However, the economic crisis pushed an adjustment of welfare state regimes, although these changes took different forms across states and within (Mishra, 1990; Mishra, 1984). Mishra points to corporatist welfare states such as Austria and Sweden as experiencing little fundamental change and residual welfare states such as the United States and Britain as having experienced much more change - although he notes that both pulled back from effecting absolute rollbacks (see also Pierson, 1994). Canada and Australia, according to Mishra, charted a middle-course between these two positions. Moreover, within states

certain sectors faired better at repelling adjustment than others - health in Canada and Britain being an example of one such sector (Mishra, 1990, Chapter 5). In short, a crisis did occur across the West in the aftermath of the oil-shock, although the scope of this change varied across states. Part of the explanation for this variation is linked to the role of public support for the programmes of the welfare state (Mishra, 1990 and 1984). This coincides with the argument presented by Therborn and Roebroek (1986) concerning the irreversibility of the welfare state. For these writers the welfare state has sufficiently penetrated to the different layers of society that it finds itself protected by liberal democracy's ability to produce a supportive elective constituency. This argument will be taken up in more detail below.

1.3 Thesis outlined

This dissertation is divided into four parts. Part I, which includes this Introduction, sets forth the parameters of my comparative study. Part II contains the British case study. Chapter 3 outlines the policies and ideology of the Thatcher government as well as discussing the general themes in its social policy. Chapters 4 and 5 are the substantive discussion of policy change in British health policy under Mrs Thatcher. Part III is my Canadian case study. Chapter 6 provides the background discussion of the Mulroney government in office and the general trends in its social policy. Chapters 7 and 8 discuss the changes which occurred in health policy between 1984 and 1993. The Conclusion, Chapter 9 is found in Part IV. In it I return to the themes and issues raised in the case chapters, taking each of the dissertation's research issues in turn. Chapter 9 ends with some personal thoughts on the issue of health policy trajectories.

Through this breakdown will be proposed the argument that the New Right has had a greater impact on the British health system than the Canadian - although this overall impact has faced limits. Where New Right ideas did drive policy change, this change was found to be primarily institutional and administrative in Britain as opposed to financial in Canada. This difference can be explained by looking at the institutions of unitary and federal government as well as the shift in the ideology of British and Canadian Conservatism and how it proposed itself as an alternative to the policies and politics which had marked the Post-War. However, interest groups were not found to be a major factor in explaining this difference in policy outcome, but that where groups did have an impact on health policies, this was the result of group coalitions. Such coalitions were evident in Canada between 1984 and 1993 but not in Britain - a difference which I explain primarily by the ideological and economic tensions which separated trade union, consumer and employer groups in the health sector. Tensions which were diffused in Canada by the federal nature of its interest and professional groups.

CHAPTER TWO:

INTRODUCING THE PARAMETERS OF COMPARISON

2.0 Introductory comment

The aim of this chapter is to introduce the underlying political and historical issues relevant to my discussion of policy change in Britain and Canada under New Right government. At the root of this chapter is the notion that government policies not only reflect the present but also the past. As such, it is difficult to divorce the policies of Thatcher and Mulroney from the political and economic contexts which led to the creation of the NHS and Medicare. In addition, any discussion of change to public policy must consider the institutional parameters within which these policies operate and were created.

2.1 Government and politics in Canada and Great Britain

Fundamental to this comparison is the relative similarity which exists between the two case studies in terms of their systems of government, political processes and the organization of their public administrations. Most of Canada's political and governmental institutions are derived from Great Britain. As such, both countries are representative democracies sharing a common Head of State and Parliamentary institutions and traditions (Jackson et al., 1986, p. 89). Not surprisingly, the Canadian and British electoral and political party systems, and the parties themselves, share many features (Jackson et al., 1986, pp. 427-432; Brodie and Jenson, 1990; Judge, 1993, Chapter 3).

One of the salient features of Canada's politics pertains to the existence of sub-national identities based upon region and/or language. This is principally, but not

limited to, the case of Québec. Britain's political culture has also been marked by the presence of sub-national identities in Scotland, Wales and Northern Ireland. However, unlike Québec, they possess no measure of direct control over their economic, social or political interests as these are administered by agencies of the national government (the Scottish, Welsh and Northern Irish offices respectively). However, like Canada this sub-national cleavage has a regional/territorial dimension (Dearlove and Saunders, 1984, pp. 407-412; Jackson et al., 1986, pp. 112-115).

Although Canada's political institutions owe much to British traditions and practices, there are some interesting differences, however, which Porter (1965) brings out. The obvious difference is Canada's linguistic duality and the impact of regionalism on national policy making, although a limited parallel might be said to exist with the cases of Scotland and Wales. Class is not as determining a social and political cleavage in Canada as in Britain. While it is true that Canada, like Britain, also has 'the right schools and clubs,' membership to these is more fluid and open in Canada (Porter, 1965, especially Chapter 6). This minimal impact on social relations, note Brodie and Jenson (1980, p. 3-6), has meant the almost complete absence of class based politics in Canada. Thus, while the British Labour Party was able to surpass the Liberals and eventually form a government, in Canada the New Democratic Party (NDP) has never risen beyond third party status at the federal level. Culturally, like the British, Canadians show a great respect for the rule of law, democratic principles, and certain collectivist notions - including a greater acceptance of a role for and involvement of the state in the lives of citizens than might be common to find in the United States, with which Canada is often compared (Jackson and Jackson, 1994, pp. 74-78). These collectivist leanings played an

important part in the development and maintenance of both Canadian and British social policy and are a key element of the irreversibility thesis which I examine below.

As the argument presented below is primarily an institutional one, it is important to contrast Canada and Britain in terms of their relative concentration of authority in the national government. Most will know that Canada is a highly decentralized federation while Britain is a much more centralized unitary state. However, while these are the conventional descriptions of both states it is also true that both experienced shifts in the loci of power in recent years: towards the centre in Britain and away from the centre in Canada.

The most significant feature of Britain's system of government is the concentration of authority at the centre. As Judge notes,

> [Nor] can it be denied that Parliament ... remains the heart of the debate over 'territorial politics' in the 1990s. Both the institutional structure and ideology of the UK (sic) state have been centralist (1993, p. 160).

This concentration of authority, and many other aspects of the British political process and system, is enshrined in what is conventionally referred to as an unwritten constitution (Punnett, 1994, p. 172; Jackson et al., 1986, p. 181). Although unwritten, Britain's constitution provides the framework enabling the institutions of government to operate and from which they find legitimacy. The British Constitution defines a unitary state in which power is concentrated at the centre; while the Queen heads the state, governance resides with Parliament - in fact meaning the Prime Minister and cabinet, another constitutional convention. However, because it is based on convention the British constitution permits more flexibility in the actions of government.

This is not to say that there is no devolution of administrative responsibility. Local authorities are responsible for numerous services and programmes, as are the

Scottish and Welsh offices. However, as these are creations of Acts of Parliament their existence is at once more fluid and ephemeral (Punnett, 1994, p. 177). Whereas the existence and powers of the provincial governments are stated and defined in the Canadian Constitution in Britain Westminster can create or eliminate whole levels of sub-national government through the simple means of legislation.

Away from the centre, local government has played an important role in British public administration although this is a role largely defined by the centre. Thus, for example, local governments are responsible for administering the provision of education and health services, but only as the agents of central government. Local government has no policy-making role in so far as their activities are defined by statute (Punnett, 1994, p. 403; Grey and Jenkins, 1991, p. 448). For example, while most of the money spent by local government goes towards education, educational policies are determined by the Department for Education (Punnett, 1994, p. 423). This control over local government further extends to fiscal and financial issues.

In short, central government exercises broad power over the ultimate budgets of local government (Punnett, 1994, p. 427; Kavanagh, 1990a, p. 173). In this regard Peter Taylor (1992, pp. 46-47) has observed that the key feature of the British state is the lack of formal balance of powers within the state. Sovereignty lies squarely with Parliament. This extreme concentration of power had traditionally been mediated through a number of buffer institutions existing between the state and citizen. These buffers curbed the full application of the "potential elective dictatorship" by government through Parliament. Legitimacy for state actions meanwhile derived from a consensus among political elites as to what constituted "appropriate and legitimate behaviour" (1992, pp. 46).

Among these buffers were the civil service - apolitical through to its top grades - and a range of nominally independent institutions that included Royal Commissions and the BBC. This balance of power, Taylor suggests, was to change with the advent of the Thatcher government. Under Thatcher the buffer institutions were progressively undermined. The civil service, for example, was slowly politicized and while local authorities and trade unions were attacked - although this latter challenge clashed with the Tory belief in local autonomy. Moreover no Royal Commission was established between 1979 and 1990. Drawing on Bulpitt (1986), Taylor notes that "there is no doubt that [the] abandonment of the reciprocal autonomy stance marked a major break with old conservative statecraft" (1992, p. 47).

Although the literature makes the case that British government has been marked by the centralization of power and authority, there is a counter interpretation which sees the British state as a much less centralized authority. Thus, according to this view British governance, as derived from early English government, can be seen to be based upon the principle of "concurrent governance," where matters of high politics (taxation and legislation primarily) are dealt with by Parliament (the centre) but matters of low politics (the maintenance of order and administration) are left to local government (Judge, 1993, pp. 161-163). This principle was extended through the union with Scotland which in practice meant that Great Britain was a unitary state that allowed "a remarkable plurality of administrative structures in its constituent nations"[1] (Judge, 1993, p. 164). What gave the UK its unitary dimension was the institution of Parliament (Judge, 1993, p. 164 citing Bulpitt, 1983).

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[1] The experience of devolution in Northern Ireland between 1921 and 1972 further highlights how British 'centralization' is more flexible than the rigid descriptions of its unitary nature found in some of the literature.

In addition, although unitary in constitutional form, British practice has also enshrined the existence of parallel institutions of civil society. Thus Scotland has retained its legal and educational systems as well as a distinct church that are apart from those of Wales and England, a reality termed by Bulpitt (1983) "operational federalism" (cited in Judge, 1993, p. 165). The creation of the Scottish, Welsh and Northern Irish offices - and the expansion of their administrative ambit - marks a further intrusion of decentralization in an otherwise centralized state (Judge, 1993, p. 166).

In short,

> [While] constitutional theory emphasises (sic) centralism and the unitary nature of the United Kingdom, practice reveals a heterogeneous and decentralised (sic) administrative system for the implementation of state policies in the peripheries (Judge, 1993, p. 204).

However, as Taylor (1992) noted above, the period of the Thatcher Government was marked by a shift towards the centre in British governance. A shift evident in the central government's relationship with local authorities and its lack of concern for the 'buffer' institutions of the state.

Canada offers a broad contrast to the British case. The hallmark of Canadian politics is the constitutional division of power and federalism as these have marked the development of Canadian society and government in many ways. The *Constitution Act, 1867* (also called the *British North America Act* or simply BNA), defined the institutions of the Canadian state and the nature of the federal arrangement through a division of powers between the national government and the governments of the provinces (Jackson et al., 1986, pp. 190-192). However, the growth of the state in the Post-War created overlap between the jurisdictions of one level of government with that of another. As a consequence there are few truly 'exclusive' jurisdictions (Stevenson, 1988, p. 55). Thus,

while Britain centralized power at the centre, in Canada the federal government has also increasingly asserted its role in fields of provincial jurisdiction, particularly in the area of social policy. However, as the federal government reduced its financial contribution during the Mulroney years certain provinces - as will be noted below - clamoured for return of provincial exclusivity in these areas of policy. Health being one such area.

The federal government's 'spending power' is the means by which areas of exclusive provincial jurisdiction have been changed into *de facto* areas of concurrent power. Simply, while the federal government may have limited power or jurisdiction in certain areas, this does not prevent it from spending in these areas.[2] Health is one such area where the federal government has used its spending power to enter what is constitutionally a field of exclusive provincial jurisdiction.

The provincial role in health care provision is described in section 92.7 of the BNA. In this section the provinces are granted the powers to provide services and regulate health and related services (hospitals, asylums, charities, and eleemosynary institutions). Although the text of the BNA might lead one to understand that the provinces actually provided these services, in practice they did little other than regulate them (Stevenson, 1988, pp. 36-37). Under section 92[3] the provinces were also granted powers over "generally all matters of a merely local or private nature in the province" which encompassed what was public health care at the time of Confederation. The federal government, for its part, was granted power under Section 91 over health matters

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[2] The federal government's 'spending power' is inferred largely from two provisions of the BNA; "Raising money by any mode of taxation" and "Public debt and property." These two provisions, read together, were interpreted to mean that once the federal government had raised revenue through taxation it could then disburse these sums as it saw fit. Moreover, it could set conditions respecting these payments (Barker, 1988, p. 199).

[3] References to particular sections of the BNA are drawn from a text of the Constitution Act, 1867 and 1982 amendments reproduced in Jackson et al. (1986).

relating to native Canadians, the military, immigration, quarantine, drugs, and food. However, although the Constitution deals with health explicitly, in fact, outside of public health boards concerned mostly with contagious disease and sanitation, in 1867 health was not believed to be a matter for government involvement. The ill sought treatment in their homes and the severely ill in hospitals operated by charities and religious orders (Chandler and Chandler, 1979, p. 199). The contrast with Britain could not be greater. While the NHS was to develop incrementally from a series of policies over a 30 year period, there was never any question of which level of government would assume the responsibility for it. As I will discuss below, in Canada this question was and continues to be at the heart of discussions concerning Medicare.

While in Britain the central government exercises some measure of control over the financial and fiscal policies of local government, in Canada provincial governments have significant fiscal resources available as well as constitutionally defined taxing powers. Thus, unlike Britain, the foundations of 'Social Canada' can be found in a series of federal-provincial joint funding agreements (or fiscal federalism). A major device of early 'fiscal federalism' was the existence of conditional grants where provincial governments received federal funds only if they agreed to abide by national standards set down by Ottawa (Jackson et al., 1986, pp. 227-228; Crichton, 1990, p. 34). The scope of these conditional grants expanded dramatically during the *Big Money* era of the Post-War. The largest conditional grants, those for health and post-secondary education, would be phased out by the federal government and replaced with the Established Programmes Financing arrangement which was an entirely non-conditional granting system (Crichton, 1990, p. 34; Barker, 1988). For the purposes of this study the main federal transfer needing to be discussed is the EPF.

In summary, the development and evolution of the modern Canadian state contributed over time to a blurring of the lines of jurisdiction between the federal and provincial governments. This is more so the case when a relatively new sector, health for example, becomes one of major governmental activity. As it developed, however, Canada's health system remained consistent with the jurisdictional distinctions of 1867. While the federal government established conditions for its grants it never set out to impose a model of health care service or administration. The federal government's early health care legislation and later ones never had the objective of creating a Canadian NHS. That being said, the pendulum would swing over the years between an engaged federal presence and a disengaged one. During the Mulroney government it was not infrequent to hear federal health ministers place the issue of health squarely in the provincial court. However, in the end it remains that health in Canada is an entirely provincial field of jurisdiction and one where the presence of the federal government has been essentially limited to funding. The evolution of this role will be discussed below.

By contrast, there were few - if any - jurisdictional lines to be blurred in the British case. Although the role of local government had been the object of frequent discussions, including how it related to the NHS, these never reached the crescendo of discord common to Canada. This was to be especially true during the Thatcher era when the politics of decentralization and local autonomy would end up meaning a greater centralization of power in Whitehall and Westminster (Taylor, 1992, pp. 47-48).

2.1.1 Conservatism and the New Right

The crisis of the Welfare State heralded a change in the dominant ideology of government across the West. In the Post-War, the distributional decisions of the state

were founded upon a consensus which cut across class and political divides. During this period it appeared that ideological conviction was almost incidental to government decision making. All political parties and groups had bought in and had been rewarded by the Keynesian Welfare State (KWS). The economic crisis of post-1973 narrowed the range of distributional decisions made by the state and this returned ideological conflict to the politics of nations. This conflict occurring not only amongst but also within political parties (Kreiger, 1986, pp. 17-18). In Canada and Britain the crisis marked the rise of the New Right and a shift in the overt programmes and ideology of conservative politics. However, the main target of the New Right's policies was not the problems in the world economy which had created the post-1973 crisis, but rather the welfare state and other related institutions of social democracy. The notion of rights through citizenship was replaced by the primacy of rights through ownership and markets (Gamble, 1988, pp. 1-3). Thatcherism - and to a similar extent Mulroney's policies - being one particular national response to the crisis of the KWS (Gamble, 1988, p.20).

The main difficulty in this discussion is developing a working definition of conservatism against which to compare the New Right. John Gray (1991), for example, argues that the ideology of the British Conservative Party in the 1970s and beyond was not consistent with that which had traditionally marked its policies, principles and ideology. Brodie and Jenson (1990) note a similar passage away from the traditional politics of the Progressive Conservative Party in Canada. However, in both Canada and Great Britain the distinguishing feature of the Conservative Party's ideology appears to be its apparent lack of ideology (Tanguay, 1994, p. 120; Judge, 1993, p. 83). In the British case Gamble (1988) posits that conservatism is an ambiguous concept that has no-one single unambiguous meaning as the party has roots in several political traditions of the

19th and 20th centuries. Campbell and Christian (1996, Chapter 2), note a similar blend of political traditions prior to the 1970s. Again, in both Canada and Britain the Conservative Party is chiefly characterized by its quest for power (statecraft) (Tanguay, 1994, p. 120; Gamble, 1988, pp. 152, 211, 215). In the case of Britain, the Conservatives' ideology is marked by flexibility and ideological compromises which were defined by the parliamentary leadership of the party - in particular by its leader - as part of the broader quest for power (Judge, 1993, p. 83). This is also true in the Canadian case although this is not a characteristic only of the Progressive Conservative Party but also of the Liberals (Tanguay, 1994, p. 120).

Although politics in Canada can be described in Left-Right terms, its overarching feature is that of "brokerage politics,"[4] that is the need to build an electoral coalition from divergent and conflicting regional and 'national' identities. In the wider sense Canadian politics and the political system are not defined by ideological competition but by regional and 'national'/linguistic tensions (Brodie and Jenson, 1990; Brodie and Jenson, 1980). Thus, for example, the Progressive Conservative Party's lack of electoral success in the twentieth century arises from its inability to successfully bridge these divisions, particularly when it comes to Québec. The party's success in 1984 being directly related to Brian Mulroney's ability to form a coalition of Québécois nationalists and separatists and provincial Liberals, western populists and eastern and central traditional Tories. The collapse of this coalition coming not as a result of ideological differences but primarily

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[4] The brokerage model assumes that all interests are equally eligible for electoral appeal by parties. In practice this means that groups are included into the electoral coalition by virtue of their size - although it is generally assumed that no "single" interest will be excluded. Canadian parties therefore seek to accommodate the major ethnic, religious and regional cleavages in Canada. Moreover, the brokerage model downplays the importance of class and, with the exception of the NDP, Canadian parties do not appeal to class cleavages. Thus, in terms of their socio-economic programmes there is little to distinguish the Liberals from the Conservatives (Brodie and Jenson, 1980, pp. 3-4; see also Brodie and Jenson, 1990).

because of regional/constitutional ones (the issue of Québec's constitutional recognition) (Tanguay, 1994, p. 123; Perlin, 1985, p. 167). With regards to the ideology and programme of the Progressive Conservatives, Perlin notes,

> It has been argued that in ideological temperament and tradition the Progressive Conservative Party is quite similar to the Conservative Party of Britain. According to this view, the model of conservatism as laissez-faire economic liberal - [...] - does not fit the mainstream of opinion in the Canadian party (1985, p. 168).

The Canadian Tories have traditionally articulated a belief in "freedom through the recognition of social order" and a belief in private enterprise which did not preclude state intervention to protect the weakest members of society "or to pursue the broader collective interest" (Perlin, 1985, p. 168). In short, the party's philosophical tradition holds that "self-reliance and enterprise should be encouraged, but (it) does not place private enterprise in a central position around which everything revolves" (Perlin, 1985, p. 168, citing Robert Stanfield).

At its origins the Canadian Conservative Party[5] was founded as a reaction to the threat of US expansion. It was an alliance of Conservatives, Reformers and leading members of the French-Canadian conservatives (*les bleus*). The Tory elements (British influenced and firmly committed to the Crown and the imperial tie) would meld with the Conservatives at the time of Confederation. The main distinguishing feature of the party at the time was a belief in the importance of privilege (class and rank) and a Canadian variant of British 'one-nation' Toryism to which was added a commitment to private property. As the party of Canada's first government, the Conservatives were instrumental in defining the future shape of the Canadian nation as exemplified in the post-1867 National Policy. The government's policies were based on policies such as state

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[5] The Conservative Party added 'progressive' to its name after WW2 in order to broaden its ideological appeal and close the gap with the centrist Liberals.

intervention in industry and commerce, high tariffs, the recognition of unions and the extension of the franchise at the same time rejecting the influence on the Manchester School. These were all elements common to the Tory tradition of England at the time (Campbell and Christian, 1996, pp. 29-30). French-Canada, more collectivist in its political culture than English Canada, would also influence the thinking of Canada's Conservatives. Unfortunately, the Province of Québec would soon become barren ground for the Conservative Party and the long association of the province with the Liberal Party would begin in the aftermath of the Riel Rebellion (Campbell and Christian, 1996, p.30).

Over the next 90 years, both in and out of power, the Conservative Party would alternate between liberalism and a mild-version of 'one-nationism.' However, from the 1920s onwards, as the Liberal Party first moved and then consolidated its hold on the political centre, the ideological breadth of the Conservative Party narrowed (Campbell and Christian, 1996, p. 33). The devastation of the Depression would force the party, then in government, to move away from liberalism, a position it held to until the end of WWII.

In the Post-War the Conservative Party turned to populism and won two consecutive elections. Described by then Tory leader John Diefenbacker, the party was holding ground with a Conservatism drawn from Disraeli, Shaftesbury and MacDonald. In this vein the party saw as its role to make government the catalyst to economic growth as well as to temper private enterprise. While in power this was a simple position to hold onto, out of office this led to ideological confusion as the party tried to be at once conservative, liberal and progressive. The 1970s crisis prompted the party to draw on its 'one-nation' Tory tradition and push for an incomes policy. The business influenced

liberal tradition was in abeyance (Campbell and Christian, 1996, pp. 38-43; see also Grafftey, 1987).

The short lived leadership and government of Joe Clark marked the re-ascendance of the business liberal tradition in the Conservative Party. Not by its overt policies, Clark was generally believed to be a 'Red Tory' (in Britain a Wet) although he championed some privatizations and reductions of the state apparatus, but because his failure discredited the Tory tradition thereby opening the door to a leadership challenge from the business liberal tradition. This ascendance would coincide with the rise of the New Right in London and Washington and share much of its rhetoric and overt politics (Campbell and Christian, 1996, pp. 45-46, 47; see also Grafftey, 1987).

The ideological shift in the party was most evident in the leadership convention which pitted Clark as the defender of Canadian Toryism and Brian Mulroney as the champion of the business liberal tradition, although he vowed to protect social policy which he called "a cornerstone of our party's philosophy" (quoted in Campbell and Christian, 1996, pp. 49-51, 52; see also Mulroney, 1983; Grafftey, 1987).

As in other areas federalism and regionalism had also impacted on the nature of Canadian Conservatism. With the exception of the NDP Canadian parties at the provincial and federal level are independent entities. In the case of the Conservatives, the ties existing between it and the provincial parties are weak, or "loosely confederal" (Dyck, 1996, p. 10). Moreover, although the party is present across the country in federal politics, this is not true at the provincial level where for example there exists no provincial Conservative Party in Québec and it is a marginal party in British Columbia. According to Dyck, "this phenomenon hampers the development of a symmetrical relationship of federal and provincial parties" (1996, p. 10). The weakness of the links

between the federal and provincial Conservative Parties was exacerbated under the leadership of Brian Mulroney through his tacit alliances with, for example, the Québec Liberals and Parti Québécois and the British Columbia Social Credit Party. Moreover, there were several instances during this same period when Conservative Parties at the federal or provincial level worked to the detriment of each other (or in other provinces) on a variety of public policy issues, thereby confirming the lack of ideological consistency in Canadian Conservatism (Dyck, 1991, pp. 160, 132). This moreover emphasizes the regional/linguistic dimension in Canadian politics.

Like their Canadian counterparts the British Tories began a search for their political message on the opposition benches after 1974. Behrens (1980) notes that as a much older party the British Conservatives had broader philosophical roots and therefore more to draw upon in answering the question "what will we conserve?" (1980, p. 3). In the Post-War period that question revolved around the split between those who saw conservatism as primarily an antidote or alternative to socialism and those for whom "circumstances governed principles" (Behrens, 1980, p. 3). The second group, which Behrens terms the "Ditchers," were of the same roots as, and one might say were the inspiration of, traditional Canadian Conservatism; that is, an ideology which considered intervention by the state not only beneficial but "unavoidable in a society determined not to return to Post-War maladies" (Behrens, 1980, p. 13). More so, the social harmony required by society could only be achieved through intervention by government. As in Canada, historic Conservatism espoused a more collectivist project (Behrens, 1980, pp. 3, 13).

British Conservatism has always been concerned with the establishment and maintenance of social order. This at times required both authority and hierarchy and the

willingness for the state to act to promote these. Conservatism itself was a reaction to the liberalism of the 18th and 19th centuries, two ideological positions which eventually melded in reaction to the emergence of collectivist liberalism and socialism. A convergence made possible by a common respect for the notion of property. At this time Conservatism would also drop its critique of capitalism which was now perceived as a mode of preserving order and freedom (Gamble, 1988, pp. 54-55).

For a long period however, the primary nature of British Conservatism was rooted in the 'one-nation' tradition, the Conservatism of Disraeli, which Behrens (1980) and Perlin (1985) understand as traditional Conservatism. However, as in Canada, WWII marked the shift to a Conservatism which favoured increased state involvement in both the distribution of wealth and the regulation of the economic cycle - the Keynes-Beveridge model. Although the wartime coalition government undoubtedly assisted in this 'contagion from the left' it is the electoral defeat of 1945 which pushed the party towards the Labour Party's reconstruction plan. The Tory Party became with Labour a party of trade union enlargement, an enlarged public sector, nationalized industries and a comprehensive welfare state (Gamble, 1988, p. 62). The return to power in 1951 seemingly validated this new policy stance. In this sense the Conservative Party after 1945 was a pragmatic organization geared to one goal - power. In government the party maintained in place the Labour Party's socio-economic edifice. It neither added to it nor cut it back (Gamble, 1988, pp. 64-66) and, under Macmillan, the party set a more interventionist course for its policies as the state became involved in key economic decisions and sectors (Gamble, 1988, p. 67).

Under Heath the Conservative Party advocated policies geared towards the disengagement of the state from the economy and the end of the corporatist devices

which had marked the previous period. However, worsening industrial relations and strikes and the deep economic problems of the early 1970s led to a U-turn as once again the party and government turned to interventionism. The world economic crisis which followed the Oil-Shock worsened England's problems and Heath was defeated in the following general election.

Like Joe Clark's dispatch from power, Heath's defeat marked the point where the New Right took the initiative. At the time when Brian Mulroney succeeded Joe Clark as leader of the Conservative Party, Canada was already experiencing its first neoliberal shift in the latter half of the 1970s.[6] On the Right a number of 'think tanks,' federal and provincial governments and business leaders were challenging the orthodoxy which had helped shape Canada's public policies. Moreover, because of their longevity in office the Liberal Party was now associated with the welfare state. Under Clark's leadership the Conservatives' electoral base was an "unstable coalition of western capital and its supporters, province building politicians, and some progressive elements ... (the so-called "Red Tories") (sic)" (Brodie and Jenson, 1990, p. 263). Brian Mulroney's support as leader was cast from the same coalition minus the progressives. The three pronged approach which the Mulroney Conservatives would take into their election campaign,[7] and subsequently government, proposed a decentralization of power, a reduction in the role of the government in the economy and ending economic nationalism (Brodie and Jenson, 1990, p. 264). From this four main policies, born of neoliberalism, would be pursued:

> reorienting public policies to encourage entrepreneurship, investment and risk taking; rationalizing the management of government resources and programs;

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[6] As noted below, the change from block funding to the EPF is an example of this shift in thinking in Canada's government.

[7] See also Erickson (1995) for a discussion of the sources of Mulroney's electoral success.

> balancing the budget; and reducing both the size and role of government. The key stone of the whole construction being free trade with the United States (Brodie and Jenson, 1990, p. 266).

The shift under Thatcher marked the ascendance of the "Diehards." This school of conservatism drew philosophically from the New Right. To this group, Post-War Conservatism had "deviated from the eternal principles of limited government, sound money and moral rectitude" (Behrens, 1980, p. 3). In their attempts to change the politics and policies of the Conservative Party the "Diehards" could count on the support of New Right think tanks, one of which was started by Thatcher herself and Keith Joseph (Behrens, 1980, p. 8; see also Cockett, 1994). The victory of Thatcher, or rather the defeat of Heath, marked the ascendancy of the New Right-inspired philosophy of Conservatism. Once in office the Thatcher government would set about ending the Keynesian consensus. The state, the new dogma declared, would concern itself with "law and order and external defence, ... attend to preventive public health, provide limited social services, and certain public services, like roads and street lighting" (Behrens, 1980, p. 9). The rigour of the market was central to the new philosophy, but so was a return to social and moral responsibility to oneself and others. Re-emphasizing the role of the family, as a source of "security, health and education" was a particular tenet of the Diehard variant of conservatism (Behrens, 1980, p. 9).

As will be further discussed below the election of the Mulroney and Thatcher Conservatives concretized in political terms policies of retrenchment begun under their Liberal and Labour predecessor governments. However, the much more radical option presented by the Thatcher Tories has to be set against the much greater political and economic problems which beset the United Kingdom. To understand these conditions, the analyses of two journalists are most revealing. Handelman writes,

> The British landscape was scarred by one of the worst industrial crises in the West, and the 1980s were already proving to be one of the most traumatic decades in British history. In fewer than ten years, the country that had invented the industrial revolution had suffered the loss of a major part of its manufacturing base (1988, p. v).

The effects which this deindustrialization was to have on British society are revealed by Sampson:

> In Britain, the economic recession has hurt more because people ... looked to the imperial past and heroic WWII (sic) and confronted this with Britain's decline as a world power. Economic decline might confirm taking the Great out of Great Britain (1982, p. 34).

This sense of inevitable decline was pervasive across British society and its institutions (Handelman, 1988, p. v). On the heals of the Winter of Discontent, the recourse to the IMF and other economic and political troubles the Conservatives pledged not only to quell the industrial unrest of the previous months and thus reverse the slide towards ungovernability, but also to end the decline of Britain and restore the sheen of the 'Great' in Great Britain through the application of New Right remedies. In office the Thatcher government's strategy for turning around Britain's fortunes was predicated on a strict application of neoconservative doctrine and monetarist economic principles. The ideological ties back to Friedman and Hayek in the application of this strategy were widely apparent (Sampson, 1982, p. 42). These policies also marked a shift in the underlying philosophy of the Conservative Party itself. Thatcher's policies were a renunciation of the middle-way, Conservative Keynesianism that had marked the Heath government. Where Heath represented "massive increases in state spending, controls on prices, dividends, rents, profits and incomes and increasing the government interference in industry" Thatcherism would be about "a return to free enterprise, sound money and the rolling back of the state" (Holmes, 1985, pp. 8, 9).

While Canada also experienced the turmoil of the 1970s economic crisis, this did not similarly create a crisis of governability. Thus, as outlined in Mulroney's (1983) *Where I stand,* the Progressive Conservative message to Canadians was not about societal or economic change, but rather about fiscal prudence. In this sense Thatcherism and the Mulroney alternative differ widely in their respective goals and ambit.

Another factor differentiating the Canadian and British Conservatives was in their appeals to nationalism. While the Conservative manifestos of 1979, 1983 and 1987 made unambiguous appeals to nationalist feelings the same cannot be said of the Canadian Tories and, in fact, during the Mulroney years it was the Canadian Left and the Liberal Party which took up the mantle of defenders of the Canadian nation (see Doern and Tomlin, 1991; Barlow and Campbell, 1991). The paradox of the party of the National Policy in the 19th century becoming the party of free trade one hundred years later was seized upon in particular by opponents of the Canada-US trade accord.

Therefore, how does the Conservatism of Mulroney and Thatcher differ from that of the traditions of their parties and from each other? As I discussed above the ideologies of the Canadian and British Conservatives have swung over time between liberalism and Toryism in response to the changing economic and political circumstances of their countries. Thus, for example, the tenets of British Conservatism in the Post-War were moulded by the need for national reconstruction just as Canadian and British Conservatism of the mid- to late 1970s was shaped by the persistence of stagflation leading both to advocate incomes policies. In short, as the literature notes, if there is a Conservative ideology to be found on both sides of the Atlantic, it is an ideology which has emphasized flexibility and pragmatism in response to changing economic and political conditions (Tanguay, 1994; Perlin, 1985; Judge, 1993; Gamble, 1988). The one

constant marking Canadian and British Conservatism over time has been the belief in private property and the maintenance of social order. In government, both Mulroney and Thatcher promoted these through policies such as privatization, increased defence spending and law and order measures.

In the sense that their policies responded to the circumstances of their time the Conservative Parties of Mulroney and Thatcher can be said to be consistent with the traditions of Canadian and British Conservatism. As Tanguay (1994) and Judge (1993) note, the Conservative Party is primarily an organization geared towards achieving power. In pursuit of this goal any number of ideological twists and turns are possible and permitted. It is useful to note here the importance of the Leader in defining and articulating the policies and objectives of the party (Judge, 1993, Chapter 3; Campbell and Christian, 1996, Chapter 1). By so doing both Mulroney and Thatcher moulded their message to the electoral coalitions which they were pulling together. This is a dimension of analysis laid out by Gamble (1998) when he notes that Mrs Thatcher's success as Leader was built upon a new coalition of voters to whom her mix of British (English) nationalism and anti-declinism appealed. The enduring quality of this coalition over three elections made her brand of Conservatism consistent with the overall statecraft of the Conservative Party. The same analysis can be said to apply to Mulroney's ungainly coalition of Québécois nationalists and Western populists. A coalition which returned Mulroney to power with a second majority term - a feat unique in the annals of the Post-1919 Tory party (Campbell and Christian, 1996, Chapter 1; Grafftey, 1987).

Although I propose that Mulroney and Thatcher were consistent with the political traditions of their parties, they differ markedly on a number of policy fronts. It will therefore be my proposal throughout that Thatcherism was truer - and a more radical

exponent - of the idiom of the New Right than was Mulroney. Banting (1992) also notes the narrower ambit of Canada's neoconservatism as compared to Britain's. Thus, although there is a measure of parity in their approaches to issues such as public expenditure, defence, foreign affairs, public enterprise and law and order they differed in their social policies, their appeals to nationalism as well as their relationship with outside interests such as trade unions and professional groups. In these latter concerns the Thatcher Government held a firmer and more radical ("revolutionary" as Banting (1992) states) line than Canada's Conservatives. This may in part be explained by reference to Krieger's suggestion that the crisis of the KWS returned ideological conflict between parties to the centre of national politics. This is particularly true in Britain where the Labour Party clearly identified itself with the social democratic alternative (or further Left) - thereby permitting the Conservative Party to offer itself as the unambiguously Right of Centre alternative. The Thatcher alternative broke the Post-War consensus by staking political ground which contrasted sharply with Labour at a time when the problems of Britain seemed to required such harsh changes. In Canada, however, where the Liberal and Conservative parties gravitate around the Centre, and where the crisis of the KWS was far less pronounced and came without the problems of governability which marred British politics, ideology was much less a factor to the overall electoral equation. Thus, the Canadian Conservatives did not have to identify themselves as radical alternatives to the Liberal Party, opting instead for the mantle of prudent administrators and constitutional deal-makers. In effect, the political moderation shown on the part of the Canadian Conservatives under Brian Mulroney is reflective of the much different political and economic circumstances which needed to be addressed by the Canadian government. Unlike Britain, the low salience of class divisions, the lack of a crisis of

governability in the 1970s and the limited appeal of nationalism to Canada's electorate defined a distinctly Canadian New Right approach to government. This highlights the contextual nature of ideological divisions across polities.

However, more importantly perhaps for this discussion is not so much that Thatcher and Mulroney were consistent with the traditions of their respective conservatism but that they were inconsistent with the New Right idiom - to which they have been identified - in their treatment of health policy.

2.2 Comparative development and functioning of the Canadian and British health care systems

In the United Kingdom, in contrast to Canada, the responsibility for the provision of health care services resides with the central government through a series of innovations spanning approximately one hundred years (Roemer, 1991, p. 191). The Thatcher government's internal market reform initiative being the latest episode in the NHS' development, evolution and change. In order to situate the health policies of the Thatcher and Mulroney governments it is important to consider how the NHS and Medicare grew over time and how they are financed. Other factors in its development, history, and organization will also inform this examination of the public policy process in British and Canadian health.

One of the more striking differences between the NHS and Medicare has been the almost relentless level of activity in attempts to restructure and reorganize the former. This difference highlights my institutional argument: the British government had at its disposal the means to effect change since 1948, while this was not the case in Canada. In short, while the British government controlled the politics surrounding the creation and

evolution of the NHS, the Canadian government only had influence on the politics of creation - with the possible exception of the *Canada Health Act* discussed below.

The NHS is a centralized, entitlement based system of health care which reflects the political and institutional centralization of the British state. The main feature marking the history of the NHS is the central government's role as the moving force behind its creation and evolution. This also entailed that the NHS would mirror its creation; that is, it would be a highly centralized edifice which concentrated at the centre power over the health system. This concentration of authority over health care in Britain was not achieved without opposition. As I will show, a number of constraints stood in the way of the British government's determination to assert its dominance over this area. Particular among these have been the private and public mix of some health care services, the resistance of local authorities, as well as that of the medical profession.

As Roemer notes, the NHS "did not arise de novo in 1948" (Roemer, 1991, p. 191), but did so incrementally from a series of initiatives. However, when Britain's National Health Service was born on 5 July 1948 it was the first government administered, comprehensive, and free health care system in Western society. Its main feature - the provision of medical services free of charge to all - remains nearly fifty years after its creation. Unlike health care systems in other countries, the NHS is not based on the insurance principle (where services follow contributions), but on the basis of "universal entitlement to state medical care" (Klein, 1989, pp. 1-2; Roemer, 1991, p. 195).

While Britain's system of publicly funded health care harks back to the turn of the century it is the passage of the *National Health Insurance Act* of 1911[8] (NHI), providing

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[8] National Health Insurance became the National Insurance scheme in the Post-War.

for primary care by general practitioners for workers earning below £160 annually, which asserted a role for the state in this area of public service. The NHI Act ensured that a minimal level of health care would be received by Britain's working population while at the same time bringing on side a reticent medical profession. The 1911 Act successfully broadened access to medical care to nearly twenty-one million workers, although it left out their families and did not cover hospital expenses. Despite its limitations, the *National Health Insurance Act* was nonetheless an important milestone in the development of the future NHS. The NHI Act is also singular in that unlike the system which emerged with the creation of the NHS the 1911 Act did not create an entitlement to care. Rather, it established an insurance system where care was linked to state, employer, and employee contributions and the employee's income (Ham, 1992, p. 10; Sakala, 1990, p. 714; Roemer, 1991, p. 192). From this starting point, Britain would progressively move away from this model towards an entitlement system and programme.

While the Ministry of Health had begun to examine the expansion of National Health Insurance in 1938 these discussions were curtailed by the outbreak of WWII. However, the war years did not entirely halt the process leading towards the creation of a national health service. Two developments, the Beveridge Report on *Social Insurance and Allied Services* and the wartime Emergency Medical Service (EMS) influenced the eventual policy outcome (Ham, 1992, pp. 12-13).

The EMS both offered a working model of an allocative administrative system for health care provision as well as sensitizing senior physicians to the conditions existing in the non-voluntary and local authority hospitals (Ham, 1992, p. 12). While the former was a practical example of state-run care, the latter, by exposing physicians to conditions of

care which were unknown to them, probably had a softening effect on the BMA's membership when the NHS Act was eventually presented in 1946.

The Beveridge Report of 1942 broke further ground towards the creation of a national health service. The report made sweeping recommendations for the reform and extension of social security and health services and, as such, "added impetus to the movement for change" (Ham, 1992, p. 14). Thus, with the end of the War and the election of the Labour Party in 1945, the NHS made its way onto the agenda for Post-War reconstruction.

The Government's proposals on health policy were first outlined in a 1944 White Paper which subsequently formed the basis of the *National Health Service Act* of 1946. The NHS Act widened medical coverage to the whole of the population and, unlike the National Insurance Act, contained no exclusions (Ham, 1992, pp. 14-15; Klein, 1989, pp. 27-28).

Rather than Britain's single unified health provision system Canada possesses twelve very different health care systems in terms of their development, structure, and operation, a reflection, Roemer (1991, p. 161) suggests, of the provisions of Canada's Constitution. Provinces, as the level of government responsible for health, have pursued different policy options reflective of their needs, societies, and fiscal capacity. Thus services insured under one province's plan may not be under the plan in effect in its neighbour. However, a unifying element among these different systems[9] is the presence of the federal government and its financial commitment to a national level of insured health services.

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[9] See Crichton et al. (1990) for an in-depth discussion of the variations in services and operations of the health system in Canada.

In Canada awareness of the need for some form of publicly funded health insurance system grew out of the consequences of the Depression. This could be seen in the pages of the Cooperative Commonwealth Federation's (CCF) Regina Manifesto and its promise to institute a hospital insurance program. The historic and traditional ties to Great Britain also influenced Canadian thinking about public health insurance, catalysed by Great Britain's move towards a National Health Service (Tuohy, 1992, p. 109). As a political reaction to the mounting popularity of the CCF, MacKenzie King's Cabinet placed health insurance on the agenda of the Federal-Provincial Conference on Post-War Reconstruction. Had health insurance been adopted at that time it is likely that it would have resembled Britain's NHS (Tuohy, 1992, p. 110). However, the conference was unable to agree on health insurance due to a jurisdictional dispute concerning taxing powers and the federal government's proposals were shelved. Federal-provincial disagreement over how to ultimately pay for health insurance marking Ottawa's very first overture on the subject. This pattern would be repeated throughout the history of the development of Medicare and extend into the Mulroney era and beyond.

It is at the provincial level, thus, that the push for a publicly funded health system occurred with the passage in 1946 of the *Saskatchewan Hospitalization Act*, the first universal hospital services plan in North America (Taylor, 1987, p. 78). In the following years this model would be copied by all of the provinces and by 1961 ninety-nine percent of the Canadian population was covered by a provincial public hospital insurance plan (Chandler and Chandler, 1979, pp. 206-207). The federal government's decision to enter the health policy field was a major factor in this evolution.

The federal government's participation in the area of health care begins in 1957 with the passage of the *Hospital Insurance and Diagnostics Services Act* (HIDS). HIDS

established the conditions under which the federal government agreed to assist the provinces with the costs of provincial hospital insurance programmes. Under HIDS federal assistance equalled about fifty percent of the cost of the programme although this funding was not without strings. HIDS set down five basic conditions which the provinces were required to satisfy in order to qualify for federal assistance. These conditions were:

1. universality (90-95% of the population had to be covered by the plan);

2. comprehensiveness of medical services;

3. accessibility (reasonable access to insured services had to be guaranteed);

4. portability (residents would continue to be covered by their plan when out of province);

5. public administration (the operation of the plan had to be done by non-profit government agencies or sanctioned bodies) (Bégin, 1988, Chapter 6).

These conditions would also be included, and tightened, in subsequent legislation.

HIDS sought to establish as uniform as possible a health insurance system as could be achieved in a federal state. Recognizing that each province had a constitutional right to administer its own publicly funded plan the conditions of the HIDS Act were the broadest possible. HIDS, therefore, did not mark the creation of a Canadian health insurance plan but rather a consolidation of the provincial pre-eminence in this policy field. The Act furthered this recognition of provincial jurisdiction by defining certain types of health care as outside federal funding; tuberculosis sanatoriums, for example, were exempted from HIDS matching funds. The Act further permitted the provinces to decide how they were to finance their half of the health insurance system. Most chose general revenues in some cases supplemented with premiums or user charges (Chandler and Chandler, 1979, p. 208).

In the case of Medicare rather than the federal government catching up to provincial initiatives, here the federal government was marching ahead of most provinces as it was its willingness to fund Medicare which enabled most provinces to establish the programme.

Once again it was the CCF government of Saskatchewan that pioneered North America's first publicly funded medical care insurance plan (Gray, 1987, p. 18). In December 1959, Premier Douglas announced his government's intention to create a publicly funded medical care plan similar to the hospitalization plan. In 1961 the legislation was passed and by 1962 Medicare, as the plan came to be known, came into operation in Saskatchewan. Within five years over ninety-five percent of doctors in the province adhered to the plan. Once again the Saskatchewan plan was the model which other provinces adapted to their own needs (Gray, 1987, p. 18).

Bolstering the federal government's decision to enter this policy area were the results of the *Royal Commission on Health Services* which came out strongly in support of a universal, publicly funded medical insurance system. Thus, in 1966 the federal government presented and passed the *Medical Care Insurance Act*, or Medicare. Like HIDS Medicare was primarily a funding programme with the federal government's contribution towards medical insurance set at fifty percent of the average national cost of providing the plan. As was the case with HIDS the provinces funded their share of the programme through general revenues, or in some instances, through premiums and user charges (Chandler and Chandler, 1979, pp. 209-211). Thus, by 1966 the two elements making up Canada's health care system were in place through the device of federal-provincial cost sharing programmes. However, it is the open-endedness of the

federal government's financial commitment in these programmes which would move it to act to redefine its stake in this programme area.

2.3 Creation and administrative structure of the NHS and Medicare

The post-1948 administrative structure of the NHS was headed by the Minister of Health whose department was responsible for general policy and administration of the Service. The operational levels of service were made up of hospitals, which came under the Hospital Management Committee and the Regional Hospital Boards. Personal health services, for their part, reported to an executive council. In both cases funding was provided by the Ministry of Health (Ham, 1992, pp. 15-17).

Although the NHS proved successful at treating the sick, it was facing a number of problems, problems that were foremost financial in nature but also administrative. As can be expected a number of administrative issues came to the fore and these prompted the Government to initiate a reorganization of the NHS' administration structure in 1974. The reorganization followed upon a number of reports and studies which concluded that an administrative overhaul was required. Furthermore, in 1968 the Government created a single social services department in the Department of Health and Social Services (DHSS) (Allsop, 1995, p. 42). Thus, the meeting of these different efforts from both within and without government advanced NHS reorganization on the agenda. The reorganization took form under the Tory government's White Paper of 1973 which, besides calling for more management efficiency, also moved to strengthen the regional tier of NHS administration. These proposals were enacted in the *1973 NHS Act* (Ham, 1992, p. 25).

The 1974 reorganization had three aims; firstly, to unify health services by bringing under one authority services previously done by three. However, GPs were able to retain their independence and once again managed to stave off attempts at placing them directly under state control. Secondly, the reorganization was intended to create a better co-ordination of activity between the health authority and local government. Finally, the reorganization was to prompt better overall management of the service (Ham, 1992, pp. 25-26; Small, 1989, pp. 156-157; Allsop, 1995, pp. 48-50). Although this was a period of economic growth, the Ministry of Health was concerned with controlling and rationalizing the expansion in services. This was another theme explored in the reorganization (Allsop, 1995, p. 43). Thus after twenty-six years the NHS underwent a major restructuring.

The post-1974 NHS was to have a more unified administrative structure. Under the new structure the existing fourteen Regional Health Authorities (RHAs) remained, although their powers and responsibilities were altered to focus on the strategic planning of all community health and hospital services within their regions. Ninety new Area Health Authorities (AHAs) were created to plan and provide the comprehensive health services for their communities. This included everything from hospitals down to the community care level. It was to the new AHAs that the Family Practitioner Committees (FPCs) reported, although the reorganization did not affect the independence or the contractor status of GPs, dentists, and other professionals. Finally, at the bottom level of the administrative structure were the District Health Authorities (DHA) which were the real operational level of the new structure. In the new hierarchy districts reported to the AHA which itself reported to the RHA, which in turn reported to the DHSS. In the end it was hoped that the reorganization, and particularly the creation of authorities responsible

for specific areas, would provide a "'comprehensive' view of health care" (Allsop, 1995, pp. 50-51).

One of the key elements to this restructuring was the establishment of "multi-disciplinary teams" which relied on consensus to make decisions. The medical profession was, through these committees, given an explicit role in managing the health service (Ham, 1992, p. 26; Allsop, 1995, p. 51). Emphasis was placed on adapting management models borrowed from the private sector to the NHS. But, these changes mostly reflected the NHS' concern with finding effective means of pursuing national goals at the local level and shifting resources towards neglected groups (Ham, 1992, p. 27).

The key feature of the 1979 reorganization was the change in the role of the local authorities. Their removal as service providers can be seen as an attempt by the central government to assert its dominion over the operations of the Health Service - and thus to an even greater degree assert its policy-making role. More interestingly, perhaps, was the fact that the conventions which had protected the role of local authorities in the past did not prevent such a wide ranging change to their structure and operation (Allsop, 1995, p. 43).

Yet even as the new structure was being set up there were already calls for its further reorganization. Criticism mostly concerned lags in decision making and the number of tiers and levels of administration. These criticisms were confirmed by the 1977 House of Commons Public Accounts Committee Report (Ham, 1992, p. 28) and echoed in the terms of reference of the *Royal Commission on the NHS*. Thus this overhaul set the groundwork for the first significant NHS policy initiative of the Thatcher Government.

Because the relationship of the national government to the health system is so completely different in Canada there is no easy comparison that can be drawn between the administrative evolution of the NHS and that of Medicare. With each province solely responsible for the administration of Medicare within its borders it is not in the ambit of the federal government to administer - let alone restructure - the Canadian health system. In Canada the relationship between the levels of government is almost entirely financial, with only a limited operational/administrative input on the part of the federal government.[10] It is therefore to the financial roots that research must turn to consider the trends in Canadian health policy. That being said two measures - one financial the other quasi-administrative - highlight this distinctive role of the federal government.

In Canada, rather than funding and financing changes made necessary by administrative reforms, it was the need to allay perceived fiscal problems which prompted Ottawa to move away from open-ended grants and establish a funding regime based on block grants. Canada like most other industrial economies was facing a severe fiscal crisis and rising budget deficits in the early 1970s. Under the previously agreed funding regime the federal government was tied to contributing approximately fifty percent of all medical care costs.[11] However, this funding formula did not contain sufficient incentives for the provinces to monitor and control their health care costs. In

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[10] The best means of contrasting the role of the Canadian government with that of the British is perhaps to point out that since the creation of Medicare less than a dozen federal public servants have been responsible for the administration of the system. To find the same levels of staffing found in the British DoH and NHS one has to turn to provincial departments of health.

[11] Under the HIDS, which came into effect in 1958, federal contributions to each province was calculated as follows: Each province entitlement under the programme was equal to the sum of 25% of eligible programme expenditure per capita in that province plus 25% of eligible programme expenditures per capita in Canada, multiplied by the population of the province. Under the Medicare Act of 1967 the federal contributions were calculated by: Each province's entitlement was equal to 50% of the eligible programme expenditures in Canada, multiplied by the province's population, meaning that each province would receive an equal per capita amount (Thomson, 1991, pp. 3,4).

1969, for example, the *Task Force on the Cost of Health Services* concluded that Ottawa should restructure its health funding and improve resource use in the health system (Crichton et al., 1990, p. 34).

Negotiations to find an acceptable compromise between the federal and provincial positions failed and in 1977 the federal government restructured its transfers to the provinces through the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contribution Act*. This Act created a new funding device, the Established Programs Financing (EPF). EPF established 'block funding'; that is, the federal government transferred to the provinces a set amount of cash which the provinces could then disburse as they saw fit, provided that they met federal criteria[12](Crichton et al., 1990, p. 34; Thomson, 1991, p. 10; Madore, 1991). In addition to the cash portion of the EPF, both levels of government agreed to a transfer of federal tax points.[13] As an added incentive to the provinces Ottawa made a one-time payment of $20 per capita for the inclusion of Extended Health Care into the EPF arrangements (Thomson, 1991, p. 17; Finance Canada, 1994, p. 22). With this new fiscal arrangement and contributions regime the federal government ensured itself to be insulated from the actual costs of providing medical and hospital care.

Although, the move from conditional grants to block funding was done in the name of increasing provincial flexibility in their social programmes planning to the

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[12] Under the EPF, the total entitlements to the provinces are calculated based on the average federal per capita contribution for the base year 1975-76 financial year, cumulatively increased year by year according to an escalator. This escalator corresponds to a moving average of the gross GNP over three years. Since 1986, rate of growth of the EPF has been restrained through a number of budgetary initiatives (Madore, 1991, pp. 4-5, 9).

[13] Tax point transfer involves the federal government reducing its personal and corporate tax rates by a set percentage, which the provinces then take up by increasing their respective tax rates. Therefore, the percentage tax burden on taxpayers remains the same, but the money is now divided differently between the levels of government. In 1977 the federal government agreed to cede to the provinces 13.5 points of personal income tax and 1 point of corporate tax (Madore, 1991, p. 5).

provinces this appeared as a federal withdrawal from expensive areas of public policy that it had help create. The creation of the EPF marked the first step away from the federal government's desire to engage actively in the area of health. However, at the time of the establishment of EPF the total amount transferred to the provinces (tax points and cash) was still close to the original share of fifty percent of provincial expenses. Then in 1983 the Trudeau Liberal's subjected the EPF to its '6 and 5' anti-inflation programme, showing a willingness on the part of the federal government to forego its commitment to 50 per cent funding (Rachlis and Kushner, 1994, p. 31). Chipping away at the EPF would also be a policy of choice of the Mulroney government. The creation of the EPF is therefore interesting as it created in 1977 the policy instrument used by a later government to wean the provinces off the federal health transfer.

The creation of the EPF is also interesting as it is the first occasion on which Ottawa allied itself with the prevailing idiom of the New Right which would shortly gain power in the United States and Britain. Perhaps much like Britain's Denis Healey the change of course represented by the EPF was foisted upon the Trudeau government as a consequence of the economic crisis of the post-oil shock. However, even before this period of stagflation in Canada the Government was already concerned by the growth of the cash it transferred to the provinces without having any direct control on expenditures. The changes to EPF were primarily motivated by a desire for efficiency and cost savings on the part of Ottawa (Bégin, 1988, p. 56). Later, as Monique Bégin recounts, the Trudeau government would begin a slow slide to the Right beginning with the August 1978 announcement of $2 billion in cuts in federal spending. It is at about this time that deficit entered the lexicon of federal ministers:

> Some Liberals suddenly felt like Conservatives, talking 'deficit' instead of 'people's needs,' blindly adopting the so-called recipes of other countries in good

> economic health. It was our turn to be brutally faced with major cuts (Bégin, 1988, p. 21).

Therefore, while the EPF was primarily an administrative device, it cannot be extricated from the prevailing political and economic mood which swept across the West at this period. If the EPF was a reaction to the country's fiscal situation the *Canada Health Act* was a response to very different pressures.

One of the underlying themes of the previous section on Britain concerned the impact of what Döhler (1991) has termed inherited policies on the ability of successor governments to forge or define new policies and policy orientations. In the case of Canada one such inherited policy was that of EPF (block funding) - a mechanism which was to be used as the main policy instrument of the Mulroney Tories to control health expenditure. The second policy which the Mulroney government inherited from its predecessor - and one which would constrain the ambit of its health policy - was the *Canada Health Act.*

Malcolm G. Taylor writes,

> EPF, had represented the most massive transfer in our history of revenues (and therefore the substance of power) from the federal to the provincial governments. The *Canada Health Act*, on the other hand, appeared to the provinces ... to be the reverse: an unwarranted and powerful federal intrusion into a field of provincial jurisdiction (1986, p. 25).

The *Canada Health Act* replaced HIDS and Medicare by consolidating them and their conditions into a single piece of legislation. It did so by restating the five conditions of these Acts (public administration, comprehensiveness, universality, portability, and accessibility), and strengthening them by requiring 100 per cent coverage for all of a province's population. The main feature of the Act is its imposition of a penalty on provinces that fail to uphold these conditions. In particular, the Act for the first time obliged provinces to submit to the federal government detailed reports on how they

administered their health systems and how they disbursed federal funds for health care[14] (Taylor, 1986, pp. 25-37; Bégin, 1988, Chapter 6). How the Act came about says much about the attachment of Canadians to Medicare.

In the late 1970s and early 1980s a widespread belief existed that Canada's health system was in danger. In particular, the provinces were accused of diverting transfer payments away from Medicare and into other areas thereby threatening the system's financial viability. Likewise extra-billing by physicians was widely believed to be an impediment to access to medical care (Gray, 1987, p. 23).

Under public pressure[15] the Conservative government of Prime Minister Joe Clark turned to Emmett Hall to examine these emerging health care issues. In the interim a change of government took place and Hall's report was presented to and acted upon by a Liberal government, once again headed by Pierre Trudeau. The Hall Commission made two key observations: firstly; that the provinces were not diverting federal funds away from Medicare; and secondly, that the practices of extra-billing and user charges were indeed an impediment to access to health care (Taylor, 1987, pp. 428-429). Despite meeting with wide public approval, the Commission's report was received negatively by the provincial governments. Concerned about starting another jurisdictional row with the provinces the Trudeau Liberals sat on the Hall Report for three years. A subsequent

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[14] Incredibly, as Monique Bégin writes, before her term as federal health minister Ottawa had no statistics concerning the end use of federal outlays for health (1988, pp. 4-6).

[15] Much of the public pressure exerted on the Clark government and that of his predecessor under Trudeau came from the Canadian Labour Congress and a citizens group, the Canadian Health Coalition (CHC). This coalition included representatives of churches, trade unions, women and patient groups. The Coalition's mission statement was to save Medicare and improve the health system. The Coalition was especially vocal in its opposition to any attempt to privatize the health system and in this was supported by the provincial Liberals and the New Democratic Party at the federal and provincial level. By 1985 the Coalition had two million members (Gray 1987).

parliamentary task force (the Breau Committee) report later reconfirmed the findings and recommendations of Hall (Gray, 1987, p. 22).

Eventually, the Liberal government decided to run the risk of a federal-provincial confrontation by acting of the Hall and Breau proposals. Armed with a Department of Justice opinion stating that the federal government did have the constitutional right to stop extra-billing at the provincial level, with opinion polls showing wide public support for the federal position, and with a federal election looming, Cabinet rallied behind what was deemed a certain vote-getter (Taylor, 1986, p. 35). The result was the *Canada Health Act, 1984*. The lightning rod contained within the Act was a federal requirement that the provinces end the practice of 'extra-billing' and user charges. To the provinces "the *Canada Health Act* [was] an: unwarranted, powerful, and politically hazardous federal intrusion into a field of provincial jurisdiction" (quotation Taylor, 1987, p. 425; Tuohy, 1987, p. 285).

Unlike the other initiatives that led to the creation of Medicare, the genesis for the *Canada Health Act* was the federal government's determination to put an end to practices which public opinion and two public inquiries had identified as a clear deterrent to access to medical care (Gray, 1987, p. 23). Besides forcing the provinces to eliminate user fees and charges since 1984 the Act has also taken on a symbolic role, defining in the minds of many the conditions necessary for the preservation of Canada's health system. As such, how the Act is enforced by the federal government is widely interpreted as a gauge of Ottawa's overall stake in the health care system.

It is paradoxical perhaps that the Canadian government was engaging in a policy course aimed at preserving the decommodification of its health system at a time when in Britain the Thatcher Government was into its second mandate on a pledge to generate

value for money in the NHS. A plan which called on an increased role for the private sector. While the *Canada Health Act* can be seen as the transition point in health policy between the Trudeau Liberals and the Mulroney Tories, in Britain the transition in policy could be said to have taken the form of two enquiries, the *Royal Commission on the NHS* and the *Working Group on Inequalities in Health.*

Almost as soon as the 1974 reorganization of the NHS had been completed criticisms emerged, most of these focusing on the growth in the NHS' administrative staff. This and other sources of unrest in the Service led the government to form in 1976 the *Royal Commission on the NHS* (Merrison Commission) whose mandate was to "consider ... the best use and management of the financial and manpower resources of the NHS" (Merrison Commission, quoted in Ham, 1992, p. 29). The Working Group was also initiated by the Labour government to consider why, despite almost thirty years of comprehensive, free, and universal health care in the UK, a disparity among classes persisted when it came to the overall health status of the population. For example, while mortality rates had declined across the class spectrum, the upper classes enjoyed a much better life expectancy rate than lower classes (Roemer, 1991, p. 205; Klein, 1989, pp. 174-175). Both the Merrison and Black reports are dealt with in the following chapter as the newly elected government's reaction to these signals what I suggest were the first statements of Tory health policy under the Thatcher premiership.

2.4 Observations

What emerges from the above discussion is the degree to which centralization and the concentration of power have affected and determined the shape of both the NHS and Medicare. This is particularly evident in what Klein has termed the "politics of creation."

Beginning in 1911, the British government continuously asserted an ever increasing presence in health policy, culminating with the creation of the NHS proper in 1948. Before the outbreak of WWII the British health system was a patchwork of services, some private, some public, most coming from charitable or voluntary organizations. The War and the cultural and political changes which it engendered in the minds of the British - as can be seen in the conclusions and proposals contained in the Beveridge Report - facilitated the passage from a decentralized health system to a centralized one. The constraints, therefore, on central government activity in this area (private and public participation, local authority involvement, and opposition from the medical profession) were all either removed by the conditions of war or, as was the case with doctors, through government incentives. The result of this was the creation of an NHS resting on three institutional pillars. First, and most important, the hospital service was brought entirely into the orbit of the state. This centralization of authority over hospitals was evident in the administrative structure of the NHS both before and after the 1974 reorganization. The medical profession found itself more or less brought under state control. GPs continued to operate as independent contractors, although their wages and conditions of work were determined by the Government. Local authority participation continued to be the most decentralized level, although, as I noted above, their independence is a matter of some fluidity. Certainly under the leadership of Mrs Thatcher the independence of local government was increasingly tested. In terms of health policy, from the outset local authorities may have acted as service providers, but their terms of reference in these matters were determined elsewhere.

The centralization of control over the NHS is also evident from my discussion of its financing and of the numerous commissions which have been asked to examine its

activities, services, structure, and finance. All of the funding of the NHS either originates from central government funds or is derived from its policies, such as the introduction and increase in charges. As I will discus below, at a time when the level of spending became a priority issue of the British government, the ability of central government to determine the NHS' funding allocations will emerge as a key element of policy. This situation stands in absolute contrast to the situation which existed in Canada.

Although not fully developed in political terms, the creation of the EPF and subsequent changes to the fiscal policy of the Canadian government show the mounting influence of New Right ideas on public policy. This was aptly noted by Bégin (1988, p. 21). Thus, much like Healey's Chancellorship in Britain, Canada was also forced to look at its public spending and institute curbs. This theme would be picked up with much more vigour in the policies of the Mulroney government. However, there is nothing in the development of Canada's health system, nor in its political culture or system, which leads one to believe that this was an inevitable development. Unlike the US, which is generally believed to be much more conservative, the predisposition of Canadians towards the state and state spending was generally positive (Jackson et al., 1986). In short, the development of New Right policies in Canada, and particularly under the Trudeau government, may be ascribed to a shifted political centre common to other Western democracies at this time (Damgaard et al., 1989; Gourevitch, 1988).

Institutionally there appears to be a pendulum in the role of the federal government in health policy. The swing towards involvement marked by HIDS, Medicare, and the *Canada Health Act*, and the swing away from involvement marked by the EPF. More interestingly, the creation of the EPF and the passage of the *Canada Health Act* established major institutional instruments in Canadian health policy. In the

first instance the EPF was to become a significant policy tool for the federal government in guiding health policy. The Act, on the other hand, would establish constraints on federal action as it now had to maintain a financial presence in the health system in order to ensure that provincial plans kept up national standards. The dwindling financial presence of the Canadian government and its effect on its ability to enforce the Act is discussed below. On the other hand the Act also entailed constraints on the governments of the provinces. The EPF was a massive give away to the provinces and the *Canada Health Act* was an attempt to take some power back into federal hands. Paradoxically, although in matters of health policy the federal government has limited powers, both the EPF and *Canada Health Act* were legislated with minimal provincial input and, in the case of the latter, outright opposition (Gray, 1987, pp. 23-24). This informs my later finding that the federal government can act decisively where it does not have to contend with provincial governments' jurisdictional ambit. In the case of the EPF and *Canada Health Act* Ottawa not only had constitutional jurisdiction through its spending power, it had also engineered the funding formulas - in effect trapping the provinces in an inherited policy.

Finally, the *Canada Health Act* is also exemplary of another trend, that is the mobilization of public opinion, organizations, and individuals in the protection of key elements of the welfare state. As Bégin (1988) and others (Gray, 1987; Taylor, 1986) have noted, the coming to be of the Act was directly related to the coming into action of citizens. It is they, and their representative groups, which first defined the problem and supported - actively - the solution.[16] Moreover, the episode of the *Canada Health Act* is telling as this popular commitment to Medicare continued well after 1984 and continued

[16] The lobby in support of the Canada Health Act is excellently described in Barker (1989).

to affect federal policy throughout the period of the Mulroney government. The Act, and the popular support for it, established constraints which would check any New Right rollback in Canada. There would be other evidence of popular support for social policy after 1984.

PART II, CHAPTER THREE:

FOUNDATIONS TO THATCHERIST HEALTH POLICY

3.0 Introductory comments

The previous two chapters outlined the general approach taken in this research and the institutional and political foundations upon which my comparison is based. This chapter, and a similar one at the beginning of Part III, aims to add to these foundations by beginning the narrowing of the field of investigation to that of health care. To begin with I consider the major themes in the policies and politics of the Thatcher Government, in particular the developments in other sectors of social policy which may also inform those which occurred in health. The justification for this examination lies in my understanding of health as one element in overall social policy and that as such it should show similar policy trajectories as other programme areas. Other themes explored in this chapter relate more specifically to my discussion of policy change

3.1 The Thatcher Tories in Power

It will be my contention throughout this research that when compared strictly in terms of their political agendas and realizations Mrs Thatcher's governments were far more radical - and successful at changing or overturning established policies and institutions - than Brian Mulroney's. Although, as I will show below, this agenda was trimmed back for reasons of political expediency, it remains that the Thatcher government intervened more frequently and more broadly in health policy than Mulroney. In this it held back only from the one goal its New Right credo seemed to entail, that is, the reform of the NHS along the American 'liberal individualist' lines which

Mrs Thatcher was known to prefer (Holiday, 1992; personal interview GB 8). How broad was this agenda for change is the issue of much debate in the literature. Rhodes and Marsh (1992, p.1, 2) suggest that Thatcherism is a diffuse phenomenon on which many agree that a particular agenda was in existence, although there is much less agreement as to what this agenda consisted of. Perhaps the explanation for this 'diffuseness' lies in the fact that Thatcherism was less an ideology and more of "an instinct, a series of moral values and an approach to leadership" (Holmes, 1985, p. 51). Where analysts agree about the impact of Thatcherism is in the area of economic policy. This is further reflected across several items in the Thatcherite agenda. Neo-liberalism and monetarism were central to this economic dimension which cast the fight against inflation as a solution to Britain's economic woes. While it is true that spending restraint was first applied by Denis Healey, the Conservative government's policies were instituted with a particular zeal. Fighting inflation and cutting public spending were articles of faith among the Thatcher Tories, as exemplified by her references to 'no U turns' and 'there is no alternative' - mantras made necessary by the introduction in 1980 of the Medium-Term Financial Strategy (MTFS) (Wilks, 1993, p. 227; Bruce-Gardyne, 1984, p. 15; Riddell, 1985, p. 58; Holmes, 1985, pp. 53-54).

A survey of the Conservative Party's election manifestos highlights the main policy preoccupations of the Government and further shows consistency in the identification of problems and in the policy approaches that were proposed, thus highlighting the 'no U turn' style of governing which Mrs Thatcher brought to office.

The "five tasks" which the Conservative Party set for itself if elected in 1979 were:

> (1) To restore the health of our economic and social life, by controlling inflation and striking a fair balance between the rights and duties of the trade union movement.
>
> (2) To restore incentives so that hard work pays, success is rewarded and genuine new jobs are created in an expanding economy.
>
> (3) To uphold Parliament and the rule of law.
>
> (4) To support family life, by helping people to become home owners, raising the standards of their children's education, and concentrating welfare services on the effective support of the old, the sick, the disabled and those who are in real need.
>
> (5) To strengthen Britain's defences and work with our allies to protect our interests in an increasingly threatening world (Conservative Party, 1979, p. 7).

These pledges were echoed in the 1983 and 1987 manifestos, especially with regards to trade unions, the fight against inflation, and what has been termed the stockholding/homeowning democracy (Conservative Party, 1983, p. 9; Conservative Party, 1987, p. 9). However, certain non-priority issues in 1979 later became major areas of policy, privatization for example.

With regards to health the election manifestos restated the party's commitment to the NHS through: Firstly, the maintenance of the universality, comprehensiveness and free at point of use principles; secondly, the continued public funding at a level consistent with the requirements of the NHS' principles. On this second commitment the party was able to argue in its 1983 and 1987 manifestos that it had not only met this commitment but exceeded it as the NHS' level of funding increased in real terms between 1979 and 1987. Thirdly, the promotion of a more efficient use of the NHS' resources. In practice this meant that the Government "end[ed] Labour's vendetta against the private health sector" (Conservative Party, 1979, p. 26) by encouraging its growth and the take-up of

private insurance. Additionally, the Government would also seek to encourage the out-sourcing of goods and services and push for efficiency improvements in administration as a means of liberating moneys that could then be applied to patient care (Conservative Party, 1979; Conservative Party, 1983; Conservative Party, 1987). Of the three documents, however, it is the 1987 manifesto which stands out for its more detailed discussion of health policy in contrast to the largely 'motherhood' statements contained in the two previous. This highlights the greater political salience of NHS policy to the overall political goals of Thatcherism, especially in what proved to be its last term under 'the iron lady.'

Elected in May 1979 with 44 per cent of the vote and a 43 seat majority (Mackie and Rose, 1980, p. 349) the Thatcher government set about linking its fiscal, monetary, and interest rate policies in an attempt to curb inflationary pressures. For example, in its first budget the Government cut public spending and income tax rates and increased the Bank of England's minimum lending rate (Bruce-Gardyne, 1984, p. 29; Riddell, 1985, pp. 63-65). However, these were but the first steps in a larger project. Wilks notes that "Conservatives under Thatcher had the ambitious aim to turn the tide of economic history and reverse Britain's relative decline" (1993, p. 225), which the 1987 manifesto claimed had been achieved (Conservative Party, 1987, p. 5).

Privatization and the more efficient use of fiscal resources were two additional goals of Thatcher's economic policy. Through privatization the Government sought to reduce its stake in the economy as well as reduce its expenditures (Kavanagh, 1990b, p. 219; Roberts et al., 1991, p. 22; McLaughlin, 1993). Later the Government's privatization efforts touched upon the NHS through the contracting out of ancillary services (Ham, 1992). Improving the efficiency of the state apparatus coincided with one of Mrs

Thatcher's core beliefs that there existed scope for increasing the efficiency of programme delivery - efficiencies that would liberate moneys which could then be spent in other areas, for example health care (see Conservative Party, 1987, p. 29). This objective would be evident in a number of measures affecting the NHS between 1979 and 1990. In the end the Government's measure of how successful a department, programme, or agency performed its functions or mandate (effectiveness) was measured by how cheaply (efficiency) it did this (Dowding, 1993, p. 245). This was also true in health.

3.1.1 Summary and observations

Although a definition of Thatcherism eludes many scholars, it is nonetheless evident that there was a definite agenda at work between 1979 and 1990 - an agenda predicated on liberating the economy through a progressive reorientation - some might say retrenchment - of the state towards a number of core activities. It may not be too far from the truth to argue that the logical conclusion of the New Right agenda was to have the state as no more than the provider of law and order, national defence, and international treaty making and representation. Although the Government never lost track of its main objective, that is, to remain in power it overhauled programmes and policies on a wide variety of fronts in pursuit of its core goals. This overhaul was often sweeping and rapid in its execution. It is perhaps because of this style of execution that a concise definition of Thatcherism is so elusive as the agenda for change seemed conditioned by past successes in charting alternative courses and by the timely opening of policy windows, for example, permitting the establishment of the Ministerial Review and eventually the internal market. To this policy learning and ability to profit from changing circumstances one cannot discount the role of ideology in pushing for change, if not a

particular outcome. More so if this ideology was defined by the instincts, morality and style of leadership of an individual, in this case the leader of the Government (Holmes, 1985, p. 51).

Many of the issues raised by the Thatcher government will find echo in those of the Mulroney government, although they differed in the breadth of the reform agenda pursued. This difference being largely the consequence of the different levels of control each held over the levers of policy and implementation. Thus, from the monetarist policies through to its fiscal objectives the British government faced fewer institutional barriers than the Canadian. While it is certainly true that some grumbling emanated from local governments, the British government had not only the will to push through restraint and efficiency policies but also the policy tools to do so. As a result the Thatcher government was fairly successful in meeting its goals. A good example of a successful public expenditure reduction policy - with equally interesting social policy ramifications - is found in the area of public housing discussed below.

3.2 Social policy

Overall welfare state and social policies had a unique place in the priorities of the Thatcher government where the desire to roll back the state extended not only to the economy but also to the entitlements of its citizens. Mrs Thatcher noted that "the balance of our society has been increasingly tilted in favour of the state at the expense of individual freedom" (in Conservative Party, 1979, p. 5). As such, the Thatcher Tories believed in a return to a form of "Victorian values" which emphasized self-help and voluntary activities (Richardson, 1993, p. 2; see also Conservative Party, 1979, p. 27). This coupled nicely with the administration's general determination to hold down public

expenditure (Riddell, 1989, p. 138; Oliver, 1990, p. 97; Hill, 1993, p. 123). Ministers, such as Norman Fowler and Geoffrey Howe, were regularly tying together economic considerations, such as taxation and state expenditures, with the overall scope of the welfare state (Riddell, 1989, p. 139). For example, in 1982 then Chancellor Geoffrey Howe commented:

> There are powerful reasons why we must be ready to consider how far private provision and individual choice can supplement, or in some cases possibly replace, the role of Government in health, social security (sic) and education. Most of these reasons are economic (quoted in Riddell, 1985, p. 139).

In its social policies the Thatcher government would chose to emphasize three priorities: Private over public provision; consumer choice; and public expenditure restraint. These priorities would be most evident in the areas of housing, Social Security, and education.

Education, for example, offers two parallels to the developments which affected health. In the first case the reform of the education sector directly challenged the power of entrenched sector interests such as administrators, local governments and teachers' unions. This was done through the transfer of decision making over schools from local bodies to the parents in their capacity as consumers. This policy begun in 1980 reached its apogee with the 1988 *Education Reform Act*. The second development, also concretized in 1988, consisted of the creation of a quasi-market in education where parents would be free to chose schools for their children and where funding for schools was contingent on enrolment levels. Good schools which increased enrolment received more money and poor schools with decreasing enrolment far less. Coupled with the increased decision making power granted parents the consumer role in education was

considerably heightened as a result of these policies (Pierson, 1993, p. 248; Levacic, 1993, pp. 173-177).

In the context of this research the reforms in education are interesting for two reasons. Firstly, the recourse to a variant of the internal market as part of the reform of education point to a degree of philosophical consistency on the part of the Government. Clearly, what was deemed suitable for one sector of policy was deemed suitable for all. Moreover, the Government's pitch to citizen's concerning the reforms used the same language of consumer sovereignty as the 1990 NHS reforms, although in practice consumer choice in health after 1990 was far removed and much weaker than that exercised by parents. Secondly, the reforms in education point to the central government's institutional capacity to drive wide-ranging policy changes that broke the hold of entrenched sectoral interests on matters of policy and delivery. A similar development would mark NHS policy where the power of entrenched interests was consistently under challenge beginning with the Griffiths reforms in 1984.

Policy making in the area of Social Security was more complex. Social Security was the largest single spending programme of the British government, dwarfing defence, education, and health. It accounted for approximately thirty per cent of the Government's expenditure budget and ate up 10 per cent of the UK's GDP[1] (see Treasury, all years between 1980 and 1990, for example Treasury, 1980, p. 110), most of it in the form of direct transfers to individuals (Bradshaw, 1992, p. 84). A programme this large could not but attract the attention of Tory policy makers, particularly when controlling public expenditure was a core policy goal as it was under Thatcher. However, Social Security

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[1] Social Security expenditures, in fact, grew over the 1979 to 1990 period from a 'low' of approximately 24 per cent of expenditures in 1979-80 (Treasury, 1980, p. 110) to over thirty per cent of total Government expenditures by the 1989-90 expenditure planning period (Treasury, 1989, p. 4).

would demonstrate the limits to policy change in large, open-ended spending programmes. For example, only four per cent of the whole of spending on Social Security in 1979-80 was 'cash limited,' meaning the remaining 96 per cent of expenditures were generated by demand. Thus, while estimates of spending for Social Security were made, these were susceptible to exogenous fluctuations. For example, as the 1980s economic recession dragged on Social Security expenditures increased rather than decreased as the Government had planned (Treasury, 1981, p. 120; Bradshaw, 1992, p. 87). However, the Government's ability to alter the Social Security system was limited by a strong "supportive consensus" (Key, 1964, p. 69) which, as is the case with the NHS, shielded Social Security from massive reforms. This consensus prevented some of the more radical reform solutions which would have generated the greatest savings (Bradshaw, 1992, p. 98). In this regard Bradshaw states, "... anxiety about the social and political cost of policy changes weighed against the radical cuts that Thatcherite fiscal policy called for" (Bradshaw, 1992, p. 97). Moreover, as a programme engrained in the political culture Social Security repelled change, therefore only permitting reforms on the margins of the system (Bradshaw, 1992, p. 98).

3.2.1 Housing

Although the Government met with only mixed success in its reforms of Social Security , the case of housing shows a quite different outcome. The Thatcher government's housing policy was central to the Government's goal of creating a property owning democracy. As such, housing was one of the Government's most active policy areas between 1979 and 1989 - in this period seventeen pieces of legislation were passed touching on housing in one form or other (Williams, 1992, p. 165). Housing was also

closely tied to the overall direction of the Government's social policies, which favoured provision of services to those most in need. This qualification would become more prevalent in the housing sector over the years, particularly after the reform of the housing benefit in 1986. Also underlying the Government's housing policies was the Government's primary concern with limiting public expenditure. This was to be realized through a determination of what the country, the Government in fact, could afford in terms of programme spending; a determination to target public spending to those most in need (possibly through means testing); and finally, to improve the efficient use of public finance and improve the general value for money return on public funds (especially through a reliance on private sources of capital) (Treasury, 1981, p. 82; Kemp, 1992).

The Thatcher government's housing policies were first outlined in the Conservative Party's 1979 election manifesto. The main objective of this policy was to increase the level of home ownership among the population. In doing so the party was staking its electoral future on the belief that Britons aspired to home ownership. Mrs Thatcher herself noted,

> Housing is one of the many areas in which the present policies simply do not make sense. Most people want to become home-owners. Yet we devote the overwhelming majority of our resources to public rented housing.... [T]he Labour Government have pursued the traditional socialist vendetta against the private sector (quoted in Kreiger, 1986, p.73).

The key means of achieving this goal was to guarantee all council tenants the right to buy their homes - at a discount.

By 1984 the Government had sold 650,000 housing units, and in the same year it had reduced public expenditure on housing by 34 per cent in real terms. Since the sales of dwellings counted as a negative expenditure, this meant that the Government had reduced its housing expenditure by fifty per cent in five years (Treasury, 1984a, p. 9).

The Government's housing policies also affected other areas of public policy, such as local government, where the Government would push the local authorities into becoming more self-financing and profit-making, while also reducing the size of public expenditure at this level (Riddell, 1989, p. 154). However, rather than merely achieving expenditure restraint, housing is one area where the Government achieved a 'real terms' expenditure cut (Pierson, 1993, p. 254).

Williams (1992, p. 162) points to different phases in the housing policies of the Thatcher government. In the first phase, and in keeping with its manifesto promises, the government introduced the *1980 Housing Act*. The Act, and the Government's general policies, enshrined the 'Right to Buy' (RTB) in legislation and included the provision that council properties were to be sold at a discount. At the same time, the Government developed policies aimed at increasing the presence of the private sector in the provision of housing (Treasury, 1980, p. 68). In addition, the legislation changed the funding mechanism by which central government funded local government's housing provision. The result of this change was intended to force local governments to increase the rents for their properties (Treasury, 1981, p. 82; Pierson, 1993, p. 254). The Act provided two incentives to purchase one's council home: A cheap purchase price, or the prospect of higher rent if one chose to continue renting (Pierson, 1993, p. 255). It should be obvious that home ownership as a policy goal dovetails with the philosophical predisposition towards self-reliance and limiting state support only to those most in need.

The Government's policies were not simply concerned with the sale of council housing and the control of local authority housing expenditures. Beyond increasing home ownership, the Government was also keen to encourage the improvement of existing housing stock and the concentration of public resources on those individuals most in

need. In pursuit of these goals the Government improved subsidies for repair of existing housing and passed legislation guaranteeing tenants the right to repair of their premises by their landlords. The private sector, for its part, was encouraged to move into new areas such as housing for the disabled (Treasury, 1984b, pp. 51-52).

Beginning in 1987 the Government entered the second phase of its housing policies with a White Paper which recommended the creation of a competitive marketplace for housing and reducing the role of Local Authorities in housing provision. This was encapsulated in Housing Minister William Waldegrave's stated desire "to get rid of the state as a landlord," which introduced the beginning of the sale of tenanted estates to the private sector (Kemp, 1992, p. 68). The recommendations of the White Paper were contained in the *1988 Housing Act*, which introduced the 'demunicipalisation' of local government's housing stocks. This policy permitted private landlords to purchase previously Government owned blocks or flats, although tenants were permitted to opt out of these transfers. Another development was the introduction of the Housing Action Trusts (HAT). Under HAT, tenants would be permitted to manage their own blocks of flats, determine improvements and the like. HATs after a time would be transferred to the private sector (Treasury, 1985, p. 144). The important fact about HATs is that these could be created by central government without consultation with local government, although tenants were permitted to vote on the proposed change (Kemp, 1992, p. 68). Thus, under the 1988 Act the central government gave itself the right to usurp the policies, priorities, and practices of the local level of government in order to push through its goal of transferring control of properties to the private sector.

The White Paper and 1988 Act also changed the social role of government. Local Authorities, rather than provide and manage housing, were encouraged to "rethink roles

and objectives." Rather than public provision, the Local Authorities were now encouraged to seek provision by non-public bodies, use private financing when possible, match their rents to the market (generally meaning an increase), and seek partnerships among private and public bodies to provide a variety of housing options and improve quality. Tenant involvement in the management of housing estates was particularly encouraged (Treasury, 1987, p. 151).

The final major action in housing policy by the Tory government came with the passage of the *1989 Local Government and Housing Act,* which further constrained the activities of the local level. Under the 1989 Act Local Authorities were prevented from cross-subsidizing rents using local taxes with constraints applied to how local governments could use funds generated from the sale of housing and land. Similar controls were placed on local government's ability to borrow for future social housing construction (Kemp, 1992, p. 68).

The third and final phase identified by Williams relates more explicitly to the reforms in Social Security which saw housing subsidies transferred from the unit to the individual. This permitted the targeting of benefits, as well as the disentangling of public housing from the broader welfare state to one focused specifically on those more in need. These policies, further aided by the deregulation of private landlords, housing association ownership of all newly built lettings and properties by housing associations, and the extension of tax relief to housing development, had an undeniable impact on the state housing sector. RTB was a politically advantageous policy for the Tories to pursue in their first term in office. Even the Labour Party had come to terms with the basic desire of working people to own their homes (Riddell, 1989, p. 156). However, a policy favouring home ownership also managed to disenfranchise a large number of individuals

for whom home ownership was either financially impossible, or who lived in flats or homes not suitable to their needs and therefore were unwilling to purchase them (Pierson, 1993, p. 257). On the other side of the balance sheet, the Government was extremely successful in reducing both the number of flats and homes owned by the state and the level of public expenditure on housing (Kemp, 1992; Pierson, 1993; Williams, 1992). A change which also entailed taking away from Local Authorities their role as the main providers of housing in the UK and handing it to the private sector (Pierson, 1993, p. 257). However, the main push towards the private provision of rental accommodation was not similarly successful (Kemp, 1992, p. 75).

3.3 Summary and observations

Why was the Thatcher government so successful in rolling back the public provision of housing as opposed to Social Security and, as I will discuss below, health?

Unlike Social Security, housing did not benefit from the existence of a strong "supportive consensus" acting as a shield to retrenchment policies. Housing was not an entitlement programme, its clientele therefore did not comprise the whole of the British population but only a smaller and in many ways less advantaged group of individuals. The trade-off among classes - where the middle and upper classes would fund most of the cost of social housing in exchange for their own coverage under these programmes - did not occur. In fact, as the popularity of the Thatcher government's housing policy attests, those middle-income persons who did benefit from council flats were keenest to become homeowners - hardly a ringing endorsement of a social policy. The reason for this lies in British political culture where ownership is a fundamental aspiration of many Britons - irrespective of class. This, I submit, is further evident in the low ranking given by the

British public to public housing as a social welfare priority (Taylor-Gooby, 1990). Because of this it was easier for the Government to adopt a residualist stance in this area of policy. In short, public housing lacked one of the basic conditions identified by Therborn and Roebroek (1986) preventing welfare rollback: In housing, there was not a committed electorate standing in support of the existing policy.

In short, what the Thatcher government's housing policies demonstrate is that under the right social conditions it is possible not only to tinker but to change radically decade old social priorities and policies. This, I will discuss below, is strikingly different from the conditions existing in health. Finally, it is again useful to highlight the fact that although public housing was administered by the local government level, the central government's exclusive control of financial and policy making levers facilitated this policy change. Many of these themes will be reflected in the following discussion of health. An early observation however points to the early appearance of the notion that money in social provision should be attached to individuals rather than units or institutions. With the introduction of the Internal Market in 1990 the concept of "money following patients" was enshrined as an operating policy in the NHS. However, this same logic could be seen in the decision to create a transfer which would go to individuals rather than one which would go to local authorities to be turned into bricks and mortar. In this early case, money followed the most needy in the pursuit of housing, just as later money would follow the ill in the pursuit of health care.

Social Security, on both of the dimensions identified above, was perceived differently. Firstly, as a universal programme it cut across class lines. Thus all Britons could expect to benefit from the pensions aspect of Social Security. It is therefore interesting to note that the one area where the Thatcher government did alter Social

Security policies was with regards to unemployment benefits - a programme which was not an entitlement programme. On the second dimension, because of its long history at the core of British social policy Social Security could be said to have become embedded within the political culture and public consciousness. Moreover, unlike other social programmes, certain aspects of Social Security were more difficult to cast as residualist programmes. Even with the changes made to the unemployment benefit, Social Security maintained an aspect of deservedness, that is a transfer which occurred at the end of a persons working life (pensions) or to a person who had been employed but found her- or himself temporarily out of work (unemployment benefit).

Important for my discussion of health is the parity which exists between Social Security and the NHS in terms of public support. In terms of both their embeddedness in British political culture and their universalist principles they differ markedly from housing. Because of this the successive changes to, and the reforms of, the NHS under Mrs Thatcher are that much more remarkable. Although these reforms would not match the level of retrenchment found in public housing, and reform of the NHS was done on higher risk political terrain.

A final observation which can be drawn from the preceding discussion is the gradual appearance of themes and policies which would later be applied to the health sector. Thus, the internal market would be utilized in education, the concept of money following individuals in housing and improved private alternatives in all three main areas of social policy. In short, while the internal market marked a significant departure from previous NHS policies, it was not such a departure from some of the earlier policies of the Thatcher Government beginning in 1979.

In closing, despite its universal character and high level of embeddedness in the political culture the NHS will be shown to have been the site of wide-ranging policy change. As I have shown the distinction between targeted programmes and universalist one can be seen as part of the explanation underlying the differing policy outcomes between 1979 and 1990. This distinction will be shown to be relevant to my analysis of Canada as well. Having identified the factors which influenced the Thatcherite social policy agenda the following chapters apply these - and other factors - to my discussion of health.

CHAPTER FOUR:

POLICY CHANGE IN BRITISH HEALTH POLICY, FROM 1979 TO GRIFFITHS.

4.0 Introductory comment

The previous chapter discussed the political and policy environment created by the Thatcher government and how this environment came to impact on its social policies. Public housing policies, for example, were shown to have experienced broad policy change in line with the general tenets of the New Right. This chapter serves mainly to set-up the precedents which led to the broad NHS reforms of 1989-1990. It will be argued below that between 1979 and 1990 the Government addressed health policy through gradual reforms of the NHS' organization and administration. Although not a part of a 'policy chain', the reforms of 1982 and 1984 set the ground work upon which the internal market was established.

In terms of my comparative study, the reforms discussed below highlight the differences between the Canadian and British situations. Thus, there exists no parallel in the Canadian federal government's policies to the administration and organizational reforms introduced in Britain. The fact that these reforms occurred at all show the British government to have greater institutional capacity to change policy than that of the Canadian government. It will be argued below this difference is primarily the result of the institutional framework of Great Britain. In short, the Thatcher government had access to a broad variety of policy instruments and utilized these to their greatest possible extent.

Döhler (1991), divides the health policies of the Thatcher government into three, somewhat overlapping, periods each marked by a major policy drive. This chapter concerns itself with the first two of these periods, the first marked by the 1982 reorganization and the second by the Griffiths reforms.

4.1 Early initiatives

Marking the beginning of the Thatcher government's first period in health was its reaction to, and its appraisal and handling of, the reports of the Merrision *Royal Commission on the NHS* and the Black *Working Party on Inequalities in Health* - both were established by the previous Labour government of Wilson. Both reports made broad recommendations dealing with the NHS proper and the overall health system, but these failed to influence the overall health policies of the new government. In fact, Merrison's primary contribution to post-1979 NHS policy was limited to providing the context and rationale for the 1982 reorganization. A reorganization which many thought inevitable with or without Merrison (Klein, 1995, pp. 113-114). The Black Report for its part was too far out of sync with the prevailing economic and political situation to have much effect on policy. Both are discussed below. The culmination of the first period in the Thatcher government's NHS policy was marked by the 1982 reorganization, a process begun with the publication of the 1979 Green Paper, *Patients First* (DHSS, 1979). This reform and its rationale highlight many of the themes which would be made more explicit in future NHS reforms. The 1982 reorganization and *Patients First* is discussed below.

Established in 1976, the Merrison Commission was charged with the task of considering "in the interest of both patients and those who work in the [NHS] the best use of and management of the financial resources of the [NHS]" (Merrison, 1979, p. iii). To a

Government pledged to seek better use of NHS resources, cutback on NHS bureaucracy, and simplify and decentralize the Service (Conservative Party, 1979, p. 26; Hansard, 15 May 1979, c. 51), a careful selection of the Merrison Report's recommendations was required, for not all of these tallied with the general direction the government wished to take.

The Commission remarked on issues ranging from administration, to parliamentary accountability, to private sector care but its only proposal to see application in policy concerned the elimination of Area Health Authorities. These had been created as part of the 1974 reorganization. Without spelling out which level it recommended be eliminated, Merrison proposed a streamlining of administration reaching from the DHSS down to the local level. The Commission judged the 'Whitehall' administrative model ill-suited to the NHS, and further stated that the system had been "made to work." On this issue the Commission favoured realigning the relationship between the DHSS and the RHAs, with the department being responsible for national policies and the RHAs for service delivery (Merrison, 1979, pp. 35-36).

Overall many of Merrison's conclusions seemed to cut across the bow of the Government's policy objectives. For example, Merrison came out against the imposition of user charges or a shift to an insurance style system. The Commission recognized that its recommendations would increase public expenditure on health but call for these to be tied to economic growth (Merrison, 1979, p. 37). However, Merrison's proposed expenditures paled in comparison with those proposed in the Black Report.

The *Working Party on Inequalities in Health* was set up in 1977. As a document focused on health status rather than on the NHS in particular, the Black Report covered a broad area of public policy ranging from baby nutrition, to housing, to work place safety,

to social security transfers and several in between (Black, 1980, pp. 355-369). In this sense it presaged many other efforts concerned with the health of the population rather than the NHS exclusively, documents such as *Promoting Better Health* (DHSS, 1987). However, the impact of the Black Report on the Government's health policies was muted by two factors. Firstly, the Report's recommendations were largely outside of the remit of the DHSS and, secondly, at approximately £2 billion in additional spending a year these recommendations were considered excessively expensive and seen largely as an agenda for greater public expenditure (personal interview GB 5). This point was duly noted by Jenkin,

> It must be made clear that additional expenditure on the scale which could result from the report's recommendations ... is quite unrealistic ... I cannot therefore endorse the Group's recommendations (Foreword to Black, 1980, p. i).

Jenkin's reaction established early on one of the parameters of future Thatcher health policies: that is, prudence, if not restraint, in public expenditure.

As any detailed proposals concerning the NHS were conspicuously absent from the Conservative Party's election manifesto or the Government's first Queen's speech (Conservative Party, 1979; Hansard, 15 May 1979, c. 47-51), the Government's reaction to Black and Merrison provide the first indication of the direction which the Tory health policies would take.

Klein (1995, p.121) notes that the Conservative Party entered government with an ideological commitment to "minimal government and the market economy." This commitment was evident in the Thatcher government's reaction to the Merrison and Black reports, but also in the manner in which the Government proceeded with the NHS reorganization of 1982.

Both Merrison and Black proposed a number of wide ranging recommendations[1] which often transcended the limits of an NHS centred policy. This was particularly the case with the Black Report which proposed a broad welfare state reform agenda. 'Minimal government' could hardly describe the nature of the analysis and prescriptions offered by both reports. As a result neither Report made a significant impact on the policies of the Thatcher government.

Was the reaction of the Government that unusual? Would a Labour government have reacted differently to Merrison and Black? While the answer to these questions must be highly speculative it is my submission that a Labour government would not have acted very differently on the recommendations of Merrison and Black, although this might have been tempered by Labour's commitment to the welfare state. While Denis Healey was the first to embrace public expenditure restraint, there remained a commitment to the edifice of the welfare state on the part of Labour which may have influenced their response to Merrison and especially Black.

Although at the outset this initial period in the Government's health policy was marked by a reaction to initiatives launched under Labour, this period is also marked by the Government's first attempts at restructuring the NHS on a basis more akin to its New Right philosophy and idiom.

In 1982 the Government proceeded with a reorganization of the NHS along lines first outlined in *Patients First* (DHSS, 1979). Central to the thrust of this reorganization was a desire to improve NHS service delivery and efficiency through decentralization and "an attack on bureaucracy" (Wistow, 1992b, p. 101) and through the delegation of decision making to as near the point of service as possible. The decentralization of

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[1] Merrison alone made 117 recommendations (Merrison, 1979).

decision making, in particular, was a repudiation of the 'expert dominated' model of bureaucratic rationality which had been at the core of the 1974 reorganization (Klein, 1995, p. 123). As such, the 1982 reorganization was not merely an administrative exercise but also a philosophical one.

Patients First was published five months after the publication of the Merrison Report. Heralding much of the consumer centred philosophy that would mark not only the future NHS reforms of 1989, but also reforms in other areas such as education,[2] the Government's approach would be one which "[stemmed] from a profound belief that the needs of patients must be paramount" (DHSS, 1979, p. 1). This primacy of patient interest would entail the movement of decision-taking functions much closer to the individual than had been the case in the past. As such, *Patients First*, is the first concrete - consumer centred - articulation of policy that would culminate in 1989 with *Working for Patients*.

Patients First was preoccupied only with the management and structure of the NHS, and drew its proposals upon a fourfold analysis of what ailed the NHS: too many tiers of management; too many administrators; slow decision-taking; and wasted money (DHSS, 1979, p. 4). This diagnosis concisely echoed the Tory Party's manifesto and early policy pledges (Conservative Party, 1979; Hansard, 15 May 1979, c. 49-50).

The Government's approach was to concentrate its reforms on areas "which experience" suggested benefited patient services. Thus *Patients First* made four proposals:

a. the strengthening of management arrangements at the local level with greater delegation of responsibility to those in the hospital and community services;

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[2] This point is also made by Pierson (1993).

b. simplification of the structure of the Service in England, by the removal of the area tier in most of the country and the establishment of district health authorities;

c. simplification of the professional advisory machinery so that the views of clinical doctors, nurses and of the other professionals will be better heard by the health authorities;

d. simplification of the planning system in a way which will ensure that regional plans are fully sensitive to district needs (DHSS, 1979, p. 6).

The key change however was the elimination of the Area Health Authority level.

According to the Government, the consultations resulting from the publication of *Patients First* indicated strong support for its approach (Hansard, 27 October 1980, c.66) and the changes outlined duly found their way into the *1980 Health Services Act* (United Kingdom, 1980). The Act eliminated all AHAs and replaced them by DHAs and provided for changes in other areas first touched upon in *Patients First*, areas of activity such as the Family Practitioner Committees (Ham, 1992, pp. 28-30).

The 1980 Act also fulfilled the Government's promise to "facilitate the wider use of private medical care" (Hansard, 15 May 1979, c. 51) by repealing the Labour government's phase out of pay beds and by dissolving the Health Services Board set-up to oversee this policy (Klein, 1989, pp. 123, 134). Considering the virulent politics which surrounded the issue of pay beds (Merrison, 1980, p. 32) this showed that the Government was keen to enhance and facilitate the role of the private sector in health without undermining the NHS' integrity. The cancellation of the phase-out policy can also be seen as challenge to the NHS unions which had utilized industrial action to force the previous government to adopt the phase-out policy. In the post-1979 NHS the unions were generally seen as adversaries (Conservative Party, 1979; personal interview GB 9).

Also coming under the axe in 1980 was the Central Health Services Council (CHSC), a body composed of health professionals and lay people whose role was to make

recommendations on any aspect of the NHS (Ham, 1992, p. 124; Klein, 1989, p. 58). While some elements of the CHSC were retained (Ham, 1992, p. 124), the decision to axe the CHSC could be seen as an omen of the Government's later propensity to shut out professional or expert opinion from the development of health policy. This trend would be another aspect of the Tory style in office between 1979 and 1990. The axing of the CHSC can also be seen as a signal of a desire to further centralization decision-making.

At the same time that the Government was cutting itself off from the policy community, it was also taking on an extended role in the financial management of the NHS. The Secretary of State was given increased powers over Health Authorities' expenditure decisions (Ham, 1992, p. 175). While the Government took greater control over the expenditure of Health Authorities, it extended their right to seek funding outside of the DHSS, principally through fund raising activities. The fact that these moneys were 'off book,' and thus not calculated in the Exchequers calculations of health authority funding (Treasury, 1980, p. 106), leads one to imagine that the process of cost contraction was moving public bodies to seek 'private' solutions for their funding woes. If the Government was not in fact cutting funding to the NHS it appeared to be moving towards a programme whereby some non-health related capital expenditures (for example building improvements) would be funded by non-public funds.

However, beyond its concern with patient need the reorganization was also consistent with the Government's public expenditure control objectives (Hansard, 15 May 1979, c. 48; Hansard, 20 November 1980, c. 6; Conservative Party, 1979, p. 7). According to Patrick Jenkin NHS over-administration was costly and, as such, the Government's reforms were "realistic" in a time of "economic difficulty" (Hansard, 27 October 1980, c. 66, 83). With the NHS expected to find £25 million in efficiency

savings, management restructuring was seen as a step towards the goal of cost control and efficiency improvement (Treasury, 1981, p. 116). Although these benefits would not be felt for years the 1982 *Government's Expenditure Plans* stated,

> [after the reorganization] ... the new District Authorities will be better placed than the previous [AHAs and DHA] structure to identify ways of saving money and carry them into effect at the local level (Treasury, 1982, p. 45).

Shortly after the 1982 reorganization of the NHS the Government assigned Roy Griffiths the task of looking further into the management of the NHS. Griffiths' first observation would be that the reorganization had failed to devolve decision taking to the unit level (Griffiths, 1983). Unlike the *Patients First* exercise, which stated a desire for consultation on the Government's plans, Griffiths preferred to move away from analysis and consultation and towards options and action.

4.1.1 Summary and observations

The previous section has outlined the very first health related initiatives of the Thatcher government. Starting with its reaction to Merrison and Black, they provide an indication of the themes and goals which were to animate its policies, as well as the emerging political preferences which marked the distinctive policy path which distinguished it from its Labour predecessors.

At this early stage in its mandate there exists little evidence of a distinctive New Right approach to health, although we can begin to discern a pattern of preferences, for example in extending the role of the private sector. The underlying political, ideological and rhetorical framework of the Thatcher era was slowly being established. Furthermore, although it is doubtful that a long term plan was in place, with hindsight it is possible to see how some of these early initiatives and pronouncements would facilitate later

policies. As Klein notes, however, while the 1982 reorganization may have brought about fairly marginal changes - especially when compared to the reforms which were to follow - it "lay in the insights they provided in the changing nature of the health policy arena" (Klein, 1995, pp. 127).

The Government's reaction to Merrison and Black demonstrate the centrality of public expenditure restraint to the Government's approach to public policy, as exemplified in the 1979 Conservative manifesto and the Government's 1980 Budget. It is therefore all the more paradoxical that in contrast to the Mulroney government the Thatcher government would increase health spending in real terms between 1979 and 1990. Related to this issue is the Government's overall approach to public sector management and efficiency. In the case of the 1982 restructuring, the logic of the policy was at once to increase the responsiveness of, and release efficiency savings into, the NHS.

This concern with public expenditure management is also discerned in the increased powers given to the Secretary of State to direct the spending of Health Authorities. This fulfilled two possible goals. On the one hand, it would ensure that local authorities would not engage in frivolous capital spending, and, on the other hand, it further centralized authority over the NHS at the level of the central government.

The Thatcher government was also at work trying to increase its domain over the NHS in general as a result of the elimination of the AHAs - in other words stripping levels of administration which might interfere with or deflect Westminster/Whitehall policy - while at the same time responsibilizing the lowest levels of administration. This delayering of NHS administration also contributed savings towards the Government's

policy of efficiency (value for money) improvements, a key element of its inflation and public expenditure control strategy.

With regards to the policy style of the Thatcher government the reforms of 1982 differ in terms of process from those which were to follow. Feeding in part off the Merrison Report, the Government introduced its proposed reorganization plans via a consultation paper (*Patients First)*. This contrasts with the Griffiths exercise where consultations were confined to Parliamentary Committee and especially with the 1988 Ministerial Review where the Government would opt for quick, action oriented reviews where outsiders would have little opportunity to comment on the generation of policy options and where commentary on policy proposals would be tightly controlled and limited.

While the reactions of the Government to Merrison and Black cannot be characterized as a significant case of policy change, the 1982 reorganization (including *Patients First*) is significant. Prior to this reorganization the British health system was in a period of stasis and consolidation after the reorganization of 1974 instituted under the previous Labour government. Moreover, the policies begun under Denis Healey had engendered little system-wide change. The ambit of the 1982 reorganizations could therefore be described as deviating from the policy status quo. In particular, the continued presence of private health care within the publicly funded NHS facilities (cancelling the previous government's decision to phase out pay-beds) and the new requirement for these same facilities to seek extra-governmental sources for funding can be seen as bringing about a change in the distribution of financial resources in the Health Service. For provider interests particularly this policy meant entering into a clientelistic relationship with NHS institutions as well as with their patients. As for patients, the dual

private-public use of NHS facilities would alter a system where equality of access and care had been a hallmark. Finally, the elimination of the AHA changed considerably the balance of power among the Service's different levels of authority as power and responsibility were shifted *en masse* to the local level.

Finally, it is clear that the above noted reforms and changes were facilitated by the institutional environment in which the Thatcher government operated. Although the institutions of the British state cannot be said to have influenced or facilitated the shelving of the Merrison and Black reports the institutional conditions did play a larger role in the other initiatives described above.

As the sole level of government with responsibility for the NHS, the Thatcher government was able to introduce its reorganization without negotiations or interference from other levels of government and, in fact, one of the outcomes of the restructuring was to eliminate a level of authority in the NHS. The same can be said for the Government's decision to continue the pay beds policy, axe the CHSC, or institute greater controls over Health Authority health spending. This institutional capacity to effect change became more evident - and more pronounced - with other initiatives.

4.2 Improved management and the Griffiths Report

The second period in the Conservatives' NHS policy was marked by the shift away from the "rhetoric of decentralization, local autonomy and the virtues of the private sector and it replacement with the language of a centralist new managerialism" (Döhler, 1991, p. 259). This can be seen in what became known as the Griffiths Reforms.

The Griffiths Inquiry, struck in February 1983, is interesting for a number of reasons, not the least of which is the impact it made on the NHS: "the biggest change in

the NHS in its first fifty years" (personal interview GB 4). While the 1982 abolition of AHAs seemed inevitable and independent of the party in office, the Griffiths Reforms were clearly identifiable with the priorities and preferences of the Thatcher government. Moreover, because of its introduction of the separation of the managerial from the professional functions within the NHS it laid the ground work for the purchaser (managerial) - provider (professional) split that was the logic of the 1990 reforms. The Griffiths Reforms would also facilitate the reforms of 1990 by bringing together the two policy strands which predominated in the Government's thinking, that is the need to control costs and the need to orient the NHS towards its customers rather than its providers (personal interviews GB 4; GB 7; see also Pearson, 1992).

The Griffiths Inquiry was conducted over a nine month period and did not rely on wide-ranging consultation - as would a Royal Commission. As a consequence the Griffiths Inquiry cut out of the policy formulation stage a number of actors which had traditionally been part of the 'policy community/network' associated with health matters. In so doing, Griffiths eschewed analysis in favour of "recommendations on management action" (Griffiths, 1983, p. 1). As Hall (1986) has noted, sometimes the informal processes of governments are as important as the formal processes. In this instance, as a deviation from the norm of public consultation and inquiry, Griffiths appears as an institutional innovation on the part of the Thatcher government. This propensity to cut off certain actors from policy formulations and examinations would further mark the policy style of the Thatcher Tories.

The gist of the Griffiths Inquiry's observations were largely that the NHS was unresponsive to consumer demands, lacked clear lines of accountability, and did not promote the optimal utilization of the Service's resources. For example, Griffiths found

that despite the 1982 reorganization of the NHS, which included the elimination of AHAs as a tier of administration, decision-making had not moved closer to unit level. Griffiths remarked on the impossibility of divorcing the NHS from the non-medical factors which placed demands on its resources, factors which were primarily political in nature (Griffiths, 1983, pp. 11-12, 18, 23). As a recognition of these political factors, Griffiths made clear the limits of his Inquiry team's remit. The Inquiry, it was stated, was neither a search for cost cutting measures nor a personpower study, although it could be read that both would be affected by the introduction of General Managers. Furthermore, the Inquiry's role was not to seek out areas for greater private sector involvement, although the Service itself should be continually re-examining its costs and procedures to see whether some of its services could not be offered at less cost elsewhere. Finally, the Griffiths Inquiry was not a call for further NHS reorganization and, in fact, it appeared to the Griffiths team that the NHS could not sustain another restructuring (Griffiths, 1983, p. 23).

Consistent with the Inquiry's 'action over analysis' tone, Griffiths was keen that the changes be acted upon quickly, and to this end his proposed recommendations were drafted so as not to require legislation (Social Services Committee, 1984, p. 142).

The Government's reaction to the Griffiths paper was overwhelmingly positive. The Griffiths Inquiry soon became the Griffiths Reforms as the Government declared the recommendations were "non-negotiable ... [and] the 'consultation phase' [was] a mere acclamation event" (Döhler, 1991, p. 261).

Central to the Inquiry's proposals was the creation of a Health Services Supervisory Board and an NHS Management Board. The Management Board would have a chairperson and a personnel director, both of whom would come from the private

sector - preferably from "service-oriented organizations." The budget side of the NHS would be split into two operations: finance, also to be headed by a person with private sector experience, and budget management, headed by someone coming from inside the NHS (Griffiths, 1983, pp. 3-4).

The Griffiths recommendations did not end with changes at the top of the Service alone as they included the replacement of Management Teams with General Managers at all levels of the NHS (with the exception of the Family Practitioner Committees) (Döhler, 1991, p. 261). Contrary to the largely part-time post of Health Authority Chairperson, Griffiths expected the General Manager to be the 'hands on' locus of accountability and decision making (Social Services Committee, 1984, pp. 145-146). Decision taking and management were to be streamlined with the main task of the new General Managers being to "initiate major cost improvement programmes" (Griffiths, 1983, p. 5). Soon, the new General Managers would adopt a distinct operating ideology vis-à-vis the other interests in the NHS, a new ideology based on the "three 'Es', efficiency, economy and effectiveness" (Döhler, 1991, p. 261). A new operating ideology that married with the Government's order of priorities. However, by creating the General Management function the Reforms would end the practice of consensus management - at the same time pushing out provider and community interests from the administration of the NHS. This was further the case when many of the new General Managers were appointed from outside the ranks of the NHS (Social Services Committee, 1984, p. 143; Small, 1989, pp. 49-50, 161; personal interview GB 7).

Fowler signed on to the recommendations and announced that he was moving to establish the management structures proposed by Griffiths, beginning with the Supervisory Board and the Management Board. In this regard, Fowler stated, "[one] of

the best contributions we can make to patient care is the improvement of [NHS] management along the lines recommended by the Griffiths report" (Hansard, 25 October 1983, c. 167).

As I noted above, the preoccupation with cost effectiveness and the consumer interest was one of the most attractive features of the Griffiths Report for the Government. As Fowler explained, "we are looking at ways in which we can reduce the cost of the health organization in the Department and I think in many ways the Griffiths Report will help achieve that." In effect, Fowler was able to set the logic of general management within the larger goal of public expenditure restraint, part of which implied staff reductions in the NHS. "[General Management] will inevitably lead to reduced [staff] numbers" (Norman Fowler in Social Services Committee, 1984, p. 163).

In 1984, the Supervisory Board and the National Health Service Management Executive (NHSME) were established. With the Supervisory Board overlooking the operations of the NHSME the DHSS was effectively removed from the day to day running of the NHS. The Government instructed that by the end of 1985 General Managers[3] were to be appointed to head all Health Authorities (Ham, 1992, p. 32; Pearson, 1992, p. 227; Allsop, 1995, pp. 158-159).

Another innovation arising from Griffiths' recommendations, but not one dependent on the concept of general management, was the development of the Resource Management Initiative (RMI), also referred to as 'clinical budgets' (Ham, 1992, p. 35; Pearson, 1992, p. 228; Treasury, 1985, p. 159). Under this plan hospital consultants

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[3] It is interesting to note that in its 1979 consultation paper *Patients First* (DHSS, 1979) the Government rejected proposals to appoint a chief executive to be responsible for all of a Health Authority's staff. While Griffiths' 'General Manager' was envisaged to have different duties, the similarities in the proposed functions lead to questions about the Government's new found enthusiasm for the 'business-style' models it rejected three years previously.

would be allocated a set budget for the care of their patients. Although not an altogether new idea - similar plans had been proposed by the Merrison Commission - the RMI was felt to be a challenge to clinical autonomy and the decision making of health professionals (Pearson, 1992, p. 228). For the Government the aim of clinical budgeting was solely to provide clearer responsibility for consultants and others in their use of Service resources. However, rather than push through the RMI, the Government chose to proceed with pilot studies before full implementation in 1987 (Treasury, 1985, pp. 159-160). Other changes proposed by Griffiths did not benefit from similar pilot study.

While, as described, implementation soon followed publication of the Report, the Government did not act in these matters without some opposition. The NHS unions, the medical profession, and interests inside the NHS were among the severest critics of the Griffiths proposals (personal interview GB 9; Allsop, 1995, p. 158). Even among the Tory dominated Select Committee examining the Report there was dissension from the Government's general direction, marked by the public release of the Committee's Report (BMJ, 24 March 1984), although the Report itself endorsed the Government's plans (Klein, 1995, pp. 147-152).

The Griffiths Inquiry's recommendations would change significantly the way the NHS did business. Beyond establishing a clearer management structure for the Service, the Griffiths Reforms sought to clearly identify the people in charge - thereby resolving, as Griffiths analogized, Florence Nightingale's dilemma. Moreover, the Griffiths Reforms led to the separation of the executive arm of the NHS from the policy arm of the DHSS with the creation of a Management Board.[4] The Chief Executive of the NHSME was given Permanent Secretary grade and was responsible for the operational side of the

[4] Soon afterwards the Management Board would be renamed the Management Executive and the Management Executive the Executive (from NHSME to NHSE).

NHS. At the DHSS the Permanent Secretary would become responsible for overall policy and civil service matters relating to the NHS. In time this would become a position of significant political and policy importance as the Government moved its proposals arising out of *Working for Patients* (personal interview GB 7). Yet, underlying the Griffiths inspired reforms and their consequence was the prevailing desire to more effectively use the resources made available to the NHS. As with the reactions to the Merrison and Black reports and the 1982 reorganization, cost improvement and efficiency were the main justifications which moved government policy with regard to general management. This was made clear in the expenditure White Papers released in 1984 and 1985 (Treasury, 1984b, p. 80; Treasury, 1985, p. 159). It is evident that as far as the Government was concerned Griffiths was part of the search for greater efficiency leading to higher levels of services being provided at the same cost. In 1985, cost improvements, some arising from Griffiths inspired reforms, would 'inject' £100 million back into the NHS (Treasury, 1985, p. 160). As far as Government policy could be read, this was the equivalent of a cash injection into the Service.

Despite early opposition many came to agree with the general thrust of the Griffiths Report. For example from the trade unions representing NHS workers, especially COHSE, were quick to make public their opposition to the Reforms but eventually came to agree that decision taking within the NHS needed to be streamlined (personal interview GB 9). However, although the Griffiths reforms grew to have many supporters both inside and outside the Government, there existed nonetheless a case against Griffiths' analysis and subsequent reforms.

One of the objectives of the Reforms was to move towards a separation of policy functions from the political functions in management. To this end the NHSE and the post

of Chief Executive were created. However, early on this arrangement would prove impossible as the NHS, since its creation has always been a political organization where the ultimate responsibility rests with the Government and Secretary of State (Baggot, 1994, p. 36).

The Griffiths Reforms also sought to separate the provider and consumer functions of the NHS believing that consumer choice was a goal as valid for a national health system as for a supermarket. The obvious objection here was that a public not-for-profit institution cannot conform, or be expected to conform, to private sector management practice. Klein (1995) offers a different critique. He notes that the NHS lacked either incentives or sanctions as a means of improving management. Thus, although Griffiths reflected a change in the wider society towards greater consumer focused services - a similar cultural change was harder to achieve where ready incentives or sanctions did not exist. Thus,

> [Griffiths'] weakness lay not so much in seeking to impose on the NHS an approach to management drawn from the private, for-profit sector - [...] - as in assuming it was possible to change the style without also re-engineering the dynamics of the system (Klein, 1995, p. 152).

In summary, a number of key issues link the Griffiths Inquiry and subsequent reforms to the wider themes which this research explores. Clearly, the Griffiths exercise reflected the same logic of 'value for money' as the Government's in its advocacy of managerial improvements. Moreover, it attempted to apply to the NHS the same managerial models as those of the market-oriented sector of the economy - this was explicit in the suggested profile of the persons who were to fill Griffiths' new General Manager position.

Distinctive institutional features are also evident in the manner in which the Inquiry was conducted and the Reforms implemented. Firstly, the Thatcher government purposely structured the Inquiry so as to forego the usual public consultation exercises which were common to other such inquiries. Comparing Merrison and Griffiths, for example, is instructive of this difference. Secondly, the Government used its Parliamentary muscle to move through the reforms with little public debate or consultation, prompting Döhler to speak of "acclamation." Past the parliamentary stage the implementation of the Reforms could be centrally decreed and administered from Whitehall and Westminster.

Furthermore, the Griffiths Reforms were useful as a means of overriding the clinical autonomy of physicians, as well as to reduce their decision making powers, both consequences of the introduction of the RMI and the end to the consensus oriented management teams. This latter decision also reduced the decision making influence of other health sector actors such as nurses. Finally, as already noted, the exclusion or cutting off of key health sector actors from the inquiry and public consultation phase shows a government intent on broadening its own areas of direct influence and control with as little interference as possible.

Finally, while not part of a policy chain, the Griffiths Reforms were a preparatory step to the eventual creation of the internal market, the most evident connection between the two being the empowerment of managers. It is clear that without an empowered and an (at least) operationally market oriented management, the creation of the internal market - while not impossible - would have been somewhat more difficult to realize. In this sense the "three 'Es'" which Döhler mentions are also part of the credo of the management of the internal market.

Do the Griffiths inspired reforms represent a major policy change? As was the case with the 1982 reorganization, the Griffiths Reforms represents major policy change as it altered a number of fundamental relationships within the NHS. Firstly, the Reforms altered significantly the relationship among health service actors and interests. This was evident in the split at the top of the NHS structure between policy and operations with the creation of the NHSME. A similar reallocation of authority also occurred at the lower levels of the Service with the appointment of General Managers who in time would take on a set of goals somewhat at odds with those of other NHS actors. By further pushing down accountability the Griffiths Reforms were also altering a pattern of relationships which had existed since the NHS' creation in 1948.

Secondly, the Griffiths Reforms changed the complexion of NHS policy communities through its insistence on bringing in managers from outside the NHS. These would bring with them an idiom not always compatible with the Service's - partly explaining the high turnover among these outsiders (Ham, 1992, p. 153). A related measure ended the practice of consensus management at the local level. This contributed to a reduction in the policy input of the professional interests and further altered the state-provider interests relationship.

Finally, the Griffiths Reforms altered the pattern of distribution of resources within the NHS through the introduction of clinical budgeting (RMI). This measure both challenged the autonomy of the medical profession and consolidated the role of managers in the administration of health rather than simply health facilities.

On the whole Griffiths is seminal in that it set in motion the thinking that was later concretized in the Internal Market. This trajectory was no doubt assisted by Sir Roy's participation to the Ministerial Review. Griffiths was the first to try and divide the

clinical from the managerial. This was done explicitly through the introduction of General Management and implicitly through the RMI. This latter measure, in particular, by forcing doctors to examine the impact of their clinical decisions on resource utilization would prove preparatory to the Internal Market and related reforms (Klein, 1995, pp. 153, 204). Fundholding, for example, is simply an extension of this same logic. Furthermore, Griffiths can also be seen as an effort to promote consumer values over provider values (Klein, 1995, p. 152) a goal central to the thinking underlying the Internal Market. Griffiths' championing of means to improve the quality of services furthered this rebalancing away from the provider towards the patient.

In retrospect, in both its thinking and actual proposals Griffiths can be seen as preparatory to the Internal Market while being an equally significant policy in the way in which it foisted on the NHS management values which were not its own. Thus, even without the Internal Market to follow it the Griffiths Reforms marked a significant turn in NHS policy.

4.3 Summary and observations

In terms of my overall comparative study three main issues are raised by the preceding discussion. The main impetus for change in both the 1982 reorganization and the Griffiths Reforms was a desire to simplify decision making and improve administrative efficiency - as well as reducing the size of the NHS' bureaucracy. In this sense it is useful to recall that Griffiths saw his proposals as entirely consistent with the policy drives that came before his Report. These were set against a political backdrop calling for a minimal role for government and a liberating of the forces of the market. In Canada, these same concerns would also animate the social policies of the Mulroney

government. However, in this instance the Griffiths Reforms relied on a political control of the administrative functions of the health system, a control which is not held by the Canadian federal government. Thus, although both governments shared similar concerns and objectives they differed in their capacity to apply these policies.

In addition, because the areas where policy changes were actualized differed in the Canadian and British cases, so did the obstacles to change. By using administrative reforms to pursue its goals the British government would face opposition from a variety of interests ranging from professionals to trade unions - as well as the political opposition of the Labour Opposition and the interested public. In the case of the Mulroney reforms, while opposition was encountered from similar health sector interests, this opposition came from national umbrella organizations which were one step removed from the actual loci of conflict over resources, that is the level of the provinces. Therefore, while the opposition of the BMA could seriously disrupt the reforms of the Thatcher government, similar opposition from the CMA would feed the public environment without directly affecting the implementation of policy. Any reform affecting the power base of medicine - for example - would come from the provincial level of government, not the federal.

In addition, where Griffiths was clearly influential in its time and in the reforms which followed in 1990, in Canada similar recourse to 'action oriented' teams in order to chart new policy is more problematic. Even though the federal government could, and did, commission short term studies of particular issues, for example the Sherman Report (1985) on privatization, subsequent policy creation and implementation require provincial participation. Again, although not impossible, the speed with which the Griffiths recommendations were enacted highlights a greater institutional capacity in Britain than in Canada.

In the end, it is apparent that similar concerns animated the policies of both the Mulroney and Thatcher Tories, although these found different forms in policy.

CHAPTER FIVE:

POLICY CHANGE IN BRITISH HEALTH POLICY:

TOWARDS THE INTERNAL MARKET

5.0 Introductory comments

The previous chapter covered developments during what Döhler (1995) describes as the first two periods in Thatcherist NHS policy. These measures were mostly focused on managerial change and primarily concerned with improving the efficiency of the Health Service. Many of the themes identified in Chapters Three and Four, themes such as efficiency and "value for money," will again be raised below in the context of the reorganization of the NHS.

5.1 Funding and efficiency improvements

In both Canada and Britain, debate concerning the state of the health system invariably turns around the issues of funding and the cost of providing health care - issues that are in fact common across the West (see Altenstetler and Haywood, 1991). These factors made an important impact on the thinking, pronouncements, and the policies of the Thatcher and Mulroney governments. However, in Britain finding an adequate level of funding for the NHS and controlling its spiralling costs was a function of a larger goal; that is, making the utilization of resources as efficient as possible. This search for efficiency was noted in the previous chapter as the driving force behind other public policy initiatives. "The UK Government has genuinely wanted to make the best use of available public resources" (personal interview GB 5). This was no different in NHS policy.

Part of the difficulty inherent in looking back on the 'value for money' goals of the Thatcher government is in finding where these fit in terms of the larger welfare state agenda. Unlike housing, where it was determined by the Government that the market was a more efficient and responsive provider than the state - there was no similarly clear alternative to the NHS. While it is true that the Government sought to encourage the development of the private health sector, it did not turn over health to the private sector as it had done in housing. Moreover, while it is also true that the Government pursued policies which facilitated the role of the private sector within the NHS, this was limited to the provision of ancillary services not health care services. Further complicating this picture is the fact that the Thatcher government increased substantially the amount of money devoted to the NHS between 1979 and 1990 at the same time as a broad spectrum of individuals and groups were engaged in an intense debate about what they saw as the persistent underfunding of the Health Service by the Thatcher government (Butler, 1992. p. 68).

The Thatcher government learned in 1982 that any meddling with the NHS that undermined its status as a public institution would also undermine the Government's chances of re-election (Döhler, 1991, pp. 256-257). As a consequence the issue for the Government was not how to implement expenditure restraint or cuts, as was the case in Canada, but how to manage real term increases in funding with the NHS' steadily increasing needs for resources. In other words, the Government's commitment to the NHS meant not managing decline in funding but rather managing growth - without busting the national budget.

Figure 5.1 below shows the expenditures (in nominal terms) for health care in England between 1979 and 1990.[1] What it shows is that the British government invested a steadily increasing amount of money into the NHS throughout the 1979-1990 period. The significant number concerns the overall rate of growth, which averages an appreciable 13.85 per cent during this period.[2] In its first mandate the Thatcher government decreased the rate of growth in NHS funding, from approximately 12 per cent in 1981 down to approximately 5 per cent in 1986. This last figure represents a low point, for from 1986 to 1988 the percentage increases are once again on the rise averaging approximately 11 per cent between 1988 and 1991. The overall rate of increase in NHS funding for the two initial periods in the Thatcher Government's NHS policy was approximately 7 per cent, that for the third period slightly over 8 per cent. In comparison to other areas of social spending the NHS faired well under the Thatcher regime (see Treasury, all years 1980 to 1990).[3]

In this regard the Thatcher government could be said to have pursued NHS funding policies which were inconsistent with its main policy objectives, particularly the fight against inflation through public expenditure control. In this instance the contrast with Canada could not be greater. Between 1984 and 1993 in Canada the rate of growth in the funding for health fell significantly to only slightly above two percent by 1993. While the Thatcher government could point to real terms increases in NHS funding the Mulroney government for its part was forced to utilize the language of fiscal

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[1] Funding figures for England exemplify here the national trend. See also Figure 9.1 in Chapter Nine which outlines a comparison of the rate of increase in British and Canadian health expenditures (from public sources) between 1979 and 1989. It also shows the percentage of the national GDP spent on health care in both countries for selected years.

[2] Author's calculations.

[3] Expressed as a percentage of GDP British health spending between 1979 and 1990 remained at approximately six per cent, commensurate with the growth in the economy (OECD, 1995, p. 9) - a benchmark which Patrick Jenkin had set earlier.

responsibility to justify its health funding policies. How does this inform my study? Although funding of the NHS increased in real terms there existed parliamentary and extra-parliamentary opinion that despite the moneys released back into the Service through efficiency savings the NHS was suffering from chronic shortages of resources (underfunding) (Butler, 1992, p. 68; see table in Social Services Committee, 1987, p. xxi). These shortages were evidenced in the increasing length of waiting times for surgeries and other services for example (Allsop, 1995, pp. 78-86). In short, administrative and structural change to the NHS became one way for the government to save moneys thereby preventing an even more rapid escalation of NHS funding. This paradoxical policy outcome complimented the government's expenditure restraint and NHS funding policies both.[4] On the other hand, for the Mulroney government any efficiency gains made in the provision of health care would accrue to the provincial level - in other words it offered the federal level no incentive or benefit. As such, to receive the fiscal benefit it sought the Mulroney government was forced to push the fiscal button on several occasions between 1984 and 1993.

Finally, by having access to other areas of policy in which to act the Thatcher Government was able to act with minimal risk which drastic cutbacks in NHS funding might have caused. In this instance the Mulroney government also benefited from Canada's institutional arrangements as it was able to pass the odious of health service reform to the provincial level. As will be noted below, "nobody blames the feds forclosed beds." More importantly, however, this shows both the Canadian and the British Governments to be practising a policy of "blame avoidance" (Weaver, 1986).

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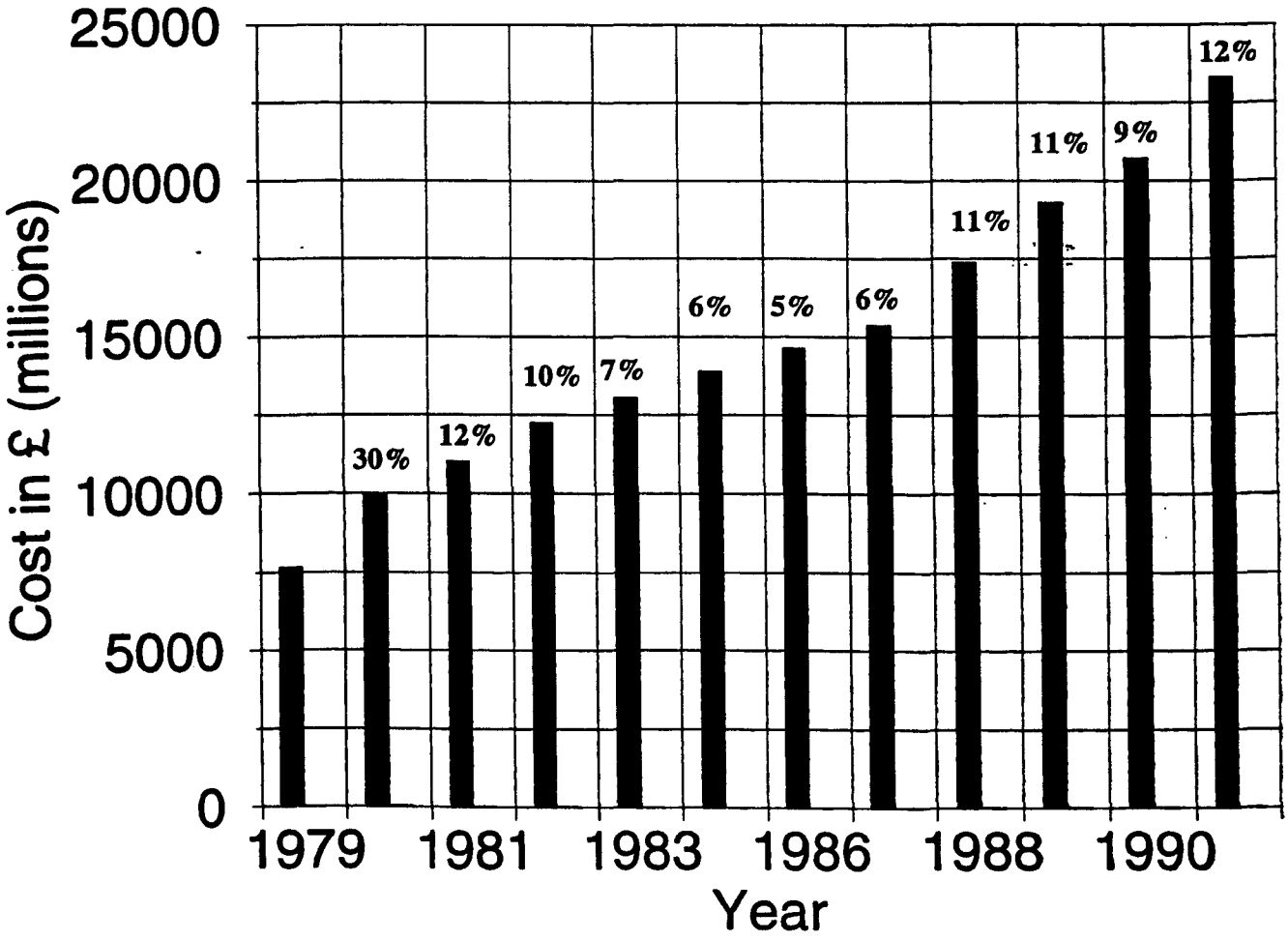
[4] Klein (1995) notes that while the funding for the NHS increased in real terms between 1979 and 1990 the historical rate of NHS funding shows that it actually declined under the Thatcher government, therefore resolving in part this paradox between expenditure restraint and a commitment to a publicly funded NHS.

Figure 5.1
NHS (England): Costs met by Government in millions of £ (Nominal figures).[1]



(Source: DHSS, 1985, pp. 15-16; DoH, 1992, pp. 15-16).

[1] Figures for year over year percentage increase calculated by the author. Figures of 1984 fiscal year were unavailable.

Despite these figures there was throughout the 1980s a persistent feeling that the National Health Service was underfunded (on various sides of this issue; see for example BMJ, 9 January 1988; Pearson, 1992, p. 219; Social Services Committee, 1988a, pp. 12). Yet neither side of this argument could state a figure at which the NHS would be optimally financed. More resources would have alleviated some of the pressures on the NHS, but no amount of money could ever hope to meet every single health need (Social Services Committee, 1988a, pp. 11-12), as Bevan and the Labour government realized early on (Klein, 1995, pp. 30-36). The Thatcher government's boast (Conservative Party, 1983, p. 22) that the NHS was treating more people, with more professional resources, and with more money than in the past was justified (see also Hansard, 21 January 1988, c. 1092; BMJ, 1 June 1985). As figure 5.1 shows, between 1979 and 1990 the central government's expenditure on the NHS rose every year (DHSS, 1985, pp. 15-16; DoH, 1992, pp. 15-16).[6] In short, throughout the period of the Thatcher government the NHS was not only 'safe with us,' it also appeared to be financially better off. Overall, between 1979 and 1990 the Government stayed close to Patrick Jenkin's stated goal that "public spending on the National Health Service has to be geared to what the country can afford ..." (Hansard, 11 December 1979, cw. 579). Similar declarations were made by other ministers and the Prime Minister (see DHSS, 1981, p. 1; BMJ, 30 May 1987; Hansard, 5 July 1988, c. 897).

The debate concerning underfunding of the NHS was primarily focused on the difference between inflation in the general economy as compared with inflation in the NHS, particularly where services were demand driven, thereby leaving the NHS with less

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[6] Similar statistics can be found in the *Government's Expenditure Plans* (Treasury, all years 1979 to 1990). However, in this case due to a change in the method used by the Government to calculate spending, year over year comparisons are more difficult.

available resources over time (Ham, 1992, p. 42; personal interview GB 7). In its 1987 report the House of Commons Social Service Committee calculated (based on King's Fund studies) that the cumulative shortfall, or underfunding, between 1980-81 and 1987-88 amounted to £1,896 billion[7] (Social Services Committee, 1987, p. xxi). The 'underfunding' itself, described by some as "a systematic policy," was dealt with by the health system through a search for more efficiency savings (personal interview GB 7; Ham, 1992, p. 42). Anthony Culyer states,

> The Government's response has been to try to force the system to confront economic reality by restricting the growth of real resources below the rate warranted by rising demand, changing demography, technological developments and rising expectations. It has used (relative) underfunding to secure greater efficiency (in Social Services Committee, 1988a, p. 239).

The Government would counter this criticism by stating that the cash released through efficiency improvements would be added to the resources of the NHS.[8] Thus, rather than consider only the amount devoted to the NHS by the public expenditure round, a better estimation of the true resources of the NHS would add together the Government's expenditure and the 'cash released' through cost improvements (Ham, 1992, p. 42; personal interview GB 7). The drive towards finding efficiencies in the health system was not unique to it, nor was it simply the consequence of the decision to limit the growth of public expenditure on the NHS. Efficiency and 'value for money' were articles of faith among the Thatcher government and from its first day in office it would steer public policy towards this goal.

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[7] Klein (1989) points to the some of the shortcomings of this calculation, for example stemming from the arbitrary choice of base year.

[8] Culyer notes that there is no "inherent systematic ... mechanism to make the service more efficient" (Social Services Committee, 1988a, p. 239). One can therefore assume from his analysis that any measure of 'efficiency' would largely be an *ad hoc* measure based simply on the fact that the NHS was not falling apart - which is the very point made by three Royal Colleges when they came out in 1987 in opposition to the Government funding policies.

The cost improvement efforts took a number of forms. Privatization and contracting out, which are discussed below, were large contributors towards the Government's efficiency goals. Another was the centrally decreed efficiency savings such as the decision to reduce staffing levels in the NHS by between 0.75 and one per cent of total staffing with Health Authorities given until March 1984 to meet the specified targets. This was followed by a cut of one per cent in NHS spending in 1983 (Pearson, 1992, p. 226). The Government also tried to improve the efficient use of resources through cost improvement programmes (CIPs). Under these, efficiency gains in service delivery were to be used to fund additional services. And, beginning in 1981-82, the Government imposed on Health Authorities explicit efficiency targets. The 1981-82 target was £30 million to which Authorities responded with savings of £29 million, £15 million attributable to efficiency improvement alone. Satisfied at this first centrally directed effort at efficiency improvements, the Government set an annual target of 0.5 per cent per year for cumulative efficiency savings with moneys saved finding their way back into patient care (Treasury, 1983, p. 58). Performance indicators which would permit the comparing of one authority with another were also introduced in 1983 (Treasury, 1983, p. 58; Pearson, 1992, p. 226). Thus, a survey of *Government's Expenditure Plans* White Papers shows the Government exacting yearly savings on the health system of £17 million in 1982-83, £100 million in 1984-85, and £171 million in 1989-90 (Treasury, 1982, p. 45; Treasury, 1987, p. 223; Treasury, 1990, p. 16).

Although growth did occur in the overall budget of the NHS between 1979 and 1990, some sectors were hit harder than others in the search for expenditure restraint, one of these being the Hospital and Community Health Services (HCHS). Between 1980-81 and 1989-90 this sector experienced an average real terms annual increase in funding of

1.6 per cent as compared with, for example, the Family Practitioner Service whose average real terms annual rate of increase was 3.5 per cent (Ham, 1992, p. 41 citing figures from a personal communication with the DoH). The reasons for this difference can be found in a 1983 DHSS report entitled *Health care and its costs: The Development of the NHS in England.* Focused primarily on the HCHS the Report restated the Government's view that a balance needed to be struck between maintaining the public commitment to the NHS and the need to find efficiencies and effectiveness improvements in the NHS. This was necessary "to keep up with soaring demands" (DHSS, 1983, p. ii). Thus, the smaller growth in the HCHS budget between 1980-81 and 1989-90 stems from the Government's success in improving patient throughput, reducing the length of hospital stays, and general productivity improvements across the HCHS (DHSS, 1983, pp. 5, 10). In short, as the HCHS became more productive its funding was paired back. Another contribution to HCHS cost improvements was the result of the Government's drive towards the contracting out of ancillary services (DHSS, 1983, p. 9). However, the major factor explaining the difference in the rates of increase is the fact that the FPS was a non-cash limited programme, as opposed to the HCHS which was cash limited. This made budgetary planning for the HCHS more predictable compared to the demand funded FPS. Approximately 80 per cent of the NHS' budget was cash limited (Treasury, 1981, p. 101; Treasury, 1985, p. 157; Treasury, 1989, p. 6) and the unpredictable nature of expenditure on the FPS caused the Government to consider the establishment of cash limits on the FPS. However, the politically explosive nature of any proposal to cash-limit the FPS, coupled with the DHSS' reluctance to close off its "relief zone," killed any such move (personal interviews GB 6; GB 7; Treasury, 1984b, p. 77). The decision to consider and then drop the cash-limitation of the FPS should also be seen in relation to

the post-Griffiths implementation of the RMI and limitations imposed on physicians prescribing budgets. These measures can be seen to highlight a view by government that for real cost improvements to occur, it was essential to change the resource utilization patterns of physicians.

In summary, it is clear that the underlying motivation of the Thatcher government was improving the efficiency of the NHS. There is in this concern nothing inherently New Right, what was different was the portrayal of public services as generally inefficient and unresponsive. However, as the numbers show, the fact remains that the Thatcher government did not cut back on its funding of the NHS in 'real' or nominal terms. There are two possible explanations for this policy course. The first, Döhler's inherited policy, reminds us that the Thatcher government was constrained by policies which had institutionalized a particular form of health service. In this instance the Thatcher government had inherited a policy which had cast the NHS as primarily publicly funded (Döhler, 1991, p. 256). This limited to a great degree the ambit of policy changes which the Thatcher government could entertain. Secondly, the inherited policy, fused with a wide socio-political consensus concerning the NHS and further limited policy change (Bosanquet, 1988, p. 97). In Canada, the publicly funded principles of Medicare would also enter into the nation's political culture and become similarly institutionalized thereby also becoming constraints to policy change. In short, while the Thatcher government controlled the policy tools required to organize a reduction in NHS funding, as was the case in housing, this did not occur due to the constraints which I have just described.

In closing, because in Britain the central government occupies all three roles in health (policy, funding and provision) it is held directly responsible by the public and

health sector professionals for the state of the NHS. Because of this the Thatcher government acted cautiously in matters of health funding. By contrast, the Canadian government, although having a role in defining national health standards through the *Canada Health Act*, shares responsibility with the provinces for the state of Medicare. This permitted the Mulroney government to cut sharply in health funding while escaping much of the blame for subsequent provincial policies dealing with these funding decisions.

However, this cautiousness on the part of the British government on funding was not matched by cautiousness in the administrative and institutional sphere. In this sphere the Government became increasingly radical in its policies as time wore on, culminating with the IM reforms of 1990. A tactic analogous to Weaver's (1986) "politics of blame avoidance."

5.2 Contracting out

Contracting out public services to the private sector was a frequently used tool of the Thatcher government's public policy. This was true in the NHS, as well as in other areas of government (personal interview GB 8; see also Treasury, 1991). The impact of this programme was largely seen in terms of its beneficial effect on overall government expenditure, as well as on the quality of services. In short, public tendering of NHS services was in line with the Conservative's belief that the private sector could do things better and cheaper (see Conservative Party, 1979; Conservative Party, 1983; Conservative Party, 1987). Another reason for the Government's recourse to contracting out was the relative size of salaries in relation to the whole of the NHS budget. Personpower, much of it unionized, accounted for approximately 52 per cent of NHS costs in 1979. By 1988

this had risen to 55 per cent (Pearson, 1992, p. 231; DHSS, 1985, p. 15; DoH, 1992, p. 15). Reducing this percentage, if not the actual number of staff, was a policy goal of the Government - especially as it offered an added opportunity to reduce trade union power[9] (personal interview GB 8). Despite its wide application in other sectors of governmental activity, for example local government (Allsop, 1995, p. 165), contracting out services was only practically available to the HCHS.

One of the problems which confronted the Government was the limited number of areas where contracting out was practical and politically acceptable. Because of this contracting out was limited to the HCHS. But even here the policy had limited applicability because the government could not be seen to be contracting out services directly geared to patient care such as nursing. Ancillary services however were far removed from patient care and, as an added benefit, these were heavily unionized segments of the NHS responsible for much of the industrial unrest of the 1970s. Therefore, the contracting out of support services was deemed both practical in terms of the efficiency saving goals and, more importantly, politically acceptable (Pearson, 1992, pp. 231-232). In 1983 the Government issued a circular to all Health Authorities requiring the public tendering of all catering, laundry, cleaning, and maintenance services with Authorities having until 1986 to complete their public tendering plans (Pearson, 1992, p. 233; Allsop, 1995, p. 165; DHSS, 1983, p. 34; personal interview GB 7). To the Government, "[public tendering was meant to] ensure that the discipline of the market tendering and pricing is brought to bear fully on the major areas of NHS spending" (DHSS, 1983, p. 34). Despite inducements to contracting out such as VAT refunds to

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[9] The issue of trade union power appears central to Conservative ideology during this period and receives detailed mention in its election manifestos (Conservative Party, 1979; Conservative Party, 1983; Conservative Party, 1987).

Authorities and the rescinding of the *1946 Fair Wages Resolution* the increased private sector penetration of the NHS was fairly limited for by 1986 only 18 per cent of all contracts had gone to private contractors (Klein, 1995, p. 161). Ironically, an unexpected development was the movement of these tendered contracts to in-house suppliers, although this was achieved only through fairly sharp cuts in wages and benefits (Pearson, 1992, pp. 233-234). At one point over 90 per cent of all contracts for support services were won by in-house providers (Klein, 1995, p. 161). The savings derived from this policy were sizeable. In 1987 it was estimated that competitive tendering had led to savings of 20 per cent, or £73 million, realized on 946 contracts for ancillary services for England and Wales (Pearson, 1992, p. 235; Allsop, 1995, pp. 165-166; both citing figures from the National Audit Office).

The rationale for the contracting out policy can be found in the Government's 1984 Green Paper *The Next Ten Years* (Treasury, 1984a) where it was argued the recourse to private alternatives for services provided by state bodies was one way in which the burden on the state could be lessened and the standard of services improved at the same time (Treasury, 1984a, pp. 20-21). In this way the Green Paper set out neatly the underlying paradigm which animated the Government's decision to pursue a policy of contracting out. However, what is important to note here was that, as with other initiatives pursued by the Thatcher Tories, efficiency improvement - and thus public expenditure control - was the key concern addressed by the policy.

The contracting out policy is significant for two reasons. Firstly, it highlights the increasing centralization of authority by the DHSS over the local level. Thus, the 1983 circular, rather than leaving the implementation of the policy to local interpretation, specified the procedures, criteria and time-table which had to be adhered to in the

tendering process. Additionally, the DHSS intervened directly on occasion to force the Health Authorities to expedite policy implementation (Klein, 1995, p. 160).

Secondly, the policy marked a managerial change by forcing managers to examine the quality and costs of ancillary services. This would foster the creation of techniques of control which would empower managers by "demonstrating that change could be introduced and resistance ... overcome" (Klein, 1995, p. 161). This latter dimension of contracting out, coupled with the changes brought about by Griffiths, can be seen to have changed the administrative environment of the NHS and thereby marked a policy change upon which the IM was later grafted.

Finally, the contracting out policy - although replicated in other areas of public policy - is interesting in the case of health as it marks the first use of the purchaser-provider split. Thus, the logic of this policy sought to separate the provision of ancillary services from their purchasers (the Health Authorities) although in this variation the split was intended to involve the private market. The intended outcome of these policies - the awarding of contracts to in-house teams or, after 1988, to other hospitals - created the first 'internal market' in the NHS.

5.3 Alternate sources of NHS funding

While my discussion to date has focused primarily on the larger policies of the Thatcher government these were paralleled by policies of a lesser ambit, policies which highlight the extent to which policy change marked by the New Right idiom were applied. Overall, although far less radical or important to the overall shape of the health sector than the IM they show the British government's willingness to institute unpopular measures and, as such, run political risks in deference to their own principles and

ideology. By contrast, the measures discussed below (principally charges and NI contributions) have no equivalent in the policies of the Mulroney government or in fact in the panoply of policy tools which were available to it.

Since its creation the NHS has been a tax financed entitlement programme with virtually all of the expenditure and funding decisions coming out of the Cabinet's budgetary allocation process. Although taxes are the source of most moneys used to fund the NHS, there is also a non-tax component to this funding which is made up of the revenue from NHS charges and National Insurance (NI) contributions (Appleby, 1992). The first indications of the Thatcher government's willingness to consider alternatives to the tax financing of health care came as a result of the *Royal Commission on the NHS*. In his Report Merrison found no grounds for changing the NHS' funding arrangements and also came out strongly against both charges or a change from a public to a 'social insurance' style system[10] (Merrison, 1979, p. 37). The Government, however, was more cautious. Patrick Jenkin refused to rule out any change to the NHS' financing:

> [on] the question of changing the basis of financing the Health Service, I am bound to say that the Government do not necessarily share the view of the Royal Commission, that a service financed almost 100 per cent. (sic) out of taxation is the right answer. No other advanced nation had chosen to go down the same route. We believe that we need to examine alternatives that may provide opportunities for additional finance, for more local autonomy and for more patient choice (Hansard, 17 July 1979, c. 1793).

It is interesting to contrast this statement with Mrs Thatcher's Foreword to *Working for Patients*, which promised that the NHS would continue to "be mainly financed out of general taxation" (DoH, 1989, p. 1; see also: Treasury, 1984, p. 76 for the same commitment). Jenkin was similarly unwilling to consider the Commission's suggestion

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[10] As far as the Merrison Commission was concerned, irrespective of the system used to finance the NHS - even one devolved to the private sector - no financial system could remove the NHS from government influence (Merrison, 1979, p. 37).

that all NHS charges be eliminated. This, he stated, was largely a consequence of the need to contain public expenditure as eliminating charges would cost the Government £200 million (Hansard, 17 July 1979, c. 1793). If this was the Government's reaction in 1979, how did both issues play out over the next decade?

The Government continued to toy with a possible transformation of the financial basis of the NHS which Jenkin linked to improvements in the quality of services. This was a more 'consumerist' angle and one not at odds with the Government's philosophical leanings (Hansard, 16 December 1980, c. 138-139; see also Hansard, 23 January 1980, c. 473; Hansard, 27 February 1980, cw. 589). Despite these early leanings no change was forthcoming. Norman Fowler, Jenkin's successor, rejected a move towards a social insurance type system (BMJ, 30 May 1987). The issue would simmer throughout most of the Thatcher period in office without any fundamental declaration on the part of Government that it was actively considering a change, with two minor exceptions: the CPRS proposals of 1982 (see below), and proposals put forward by Leon Brittan in 1988 for a social insurance model from which people could opt-out and place their contributions with a private insurer (Butler, 1992, p. 7). However, the issue of the NHS' financing would re-emerge as part of the Government's Ministerial Review launched in January 1988. As part of this review the Government would once again study social-insurance systems around the globe and the implication of this form of financing on the NHS. The Government concluding in 1988 that the existing arrangements were best (personal interview GB 5). The Prime Minister's commitment in *Working for Patients* put the issue to rest.

Charges, possibly because they married with the Conservative's predisposition towards encouraging those who had the ability to pay to do so (Butler, 1992, p. 8) did not

disappear so handily from the political limelight. Charges are levied on NHS users for a number of services, including prescriptions, dental and ophthalmic services. While these were introduced for the first time in the 1950s, their rate of growth accelerated during the 1980s (Allsop, 1995, p. 164).[11] Although the amount of money represented by charges increased between 1979 and 1990, this partial privatization was limited by inherited policy in that it had to preserve a broad range of exemptions from charges (Döhler, 1991, p. 256). Thus, although unpopular with those hit by increases in charges, this proved a minimal political risk compared with the far larger revenue which would have been raised by closing off exemptions. However, this latter option was politically unpalatable to the Government. Thus, contrary to expectations it chose to forego the larger source of revenue for a smaller, but politically more acceptable, one (Klein, 1995, pp. 162-163). In short, the place of charges as a policy instrument was negligible. That being said, for those who were not eligible for an exemption the prescription charge increased in real terms between 1979 and 1990 (personal interview GB 5; DHSS, 1985, p. p. 16; DoH, 1992, p. 16, see also Appleby, 1992; Allsop, 1995).

Klein (1995, p. 162) notes that another feature of the Government's policy on charges was marked by "cautious incrementalism" where increases fell primarily on services considered peripheral to the primary mission of the NHS: optical and dental services. Thus, for example, in April 1981 a £2 charge for sight tests was introduced. The more politically sensitive area of prescriptions also saw increases, but as noted above these increases were assumed by only 20 per cent of individuals, beginning in April 1980 (Treasury, 1980, p. 106-107).[12] By the 1990-91 financial year charges in the FPS where

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[11] Allsop's conclusions are based on her use of Office of Health Economics figures.

[12] Mrs Thatcher, in her memoirs, states that additional pressure to extend and increase charges for services came from the Treasury. These proposals, she states, she "firmly stamped on" (Thatcher, 1993, p. 609).

expected to contribute £518 million to the NHS budget; two years later the amount expected was to rise to £570 million. This compares with the £232 million in 1979-80 (Treasury, 1989, p. 1; Treasury, 1985, p. 156).

Beyond charges, another source of funds for the NHS came from NI contributions. Beginning on 1 April 1981 the Government increased the NHS contribution levied on employees in order to offset expenditure increases (Treasury, 1980, p. 100; Treasury, 1981, p. 116). Between 1981 and 1991 the percentage of the NHS budget dependent on NHS contributions grew from 8.5 percent to 15.7 per cent (DoH, 1992, p. 16).

While it could be argued that changes to NI contributions represented no more than a tax increase - as opposed to charges which had a direct commodifying effect on individual's access to health services - politically they both share a similar philosophical source. In designating a tax or charges the Government was determined to responsibilize Britons for the cost of some of their health care by highlighting specific contributions made to it. In Canada, where user charges have been banned since 1984, a similar response was unthinkable. While in real terms NI contributions or prescription charges were small as both a source of income for the Government or as a percentage of an individual's income - they nonetheless possessed a symbolic value linking use to resources.

Another revenue raising innovation encouraged by the Government was the use of the NHS's 'commercial' potential. In 1988 the Government permitted Health Authorities to encourage the commercial development of NHS facilities. For example, hospitals were permitted to rent space to commercial interests, such as shops or allowing full scale shopping centres on their properties (Butler, 1992, p. 20). Although the sums generated

by these developments were minor in terms of the overall health budget, they were a signal by Government that NHS facilities should not rely entirely on the central government for funding.

A related factor to this question is the issue of the role played by private insurance over the period and the incentives given to it by the Government. Mrs Thatcher made no secret that she greatly favoured the extension of the private sector in the provision of health care, and she championed at different times during her terms in office policies aimed at increasing tax relief for those who took out health care insurance (Thatcher, 1993, p. 606; Lawson, 1992, p. 616; Pearson, 1992, p. 221). As a result of these policies, the percentage of the British population who subscribed to private health insurance grew from 3 per cent in 1979 to approximately 12 per cent in 1991 (Allsop, 1995, p. 161, citing figures from various sources including the *Royal Commission on the NHS* and the Association of British Insurers).[13] Private health insurance was, however, not a development which arose *de novo* under the Thatcher regime as non-profit provident associations had been around before 1979. What was different about these was the Government's open endorsement of the need for the private sector to 'cohabitate,' as it were, with the NHS (Conservative Party, 1983, p. 28; Thatcher, 1993, pp. 612-613).

The first measure aimed at encouraging private health insurance included tax exemptions on premiums for low income earners and tax deductions for companies offering private health insurance to their employees.[14] This last concession alone was

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[13] The increase in the percentage of the population subscribing to private health care can be explained by a number of factors beyond Government tax policies. For example, anxiety caused by industrial disputes in the NHS or benefits packages offered by employers can also be seen as possible explanations for the popularity of health insurance. One explanation offered by Pearson (1992) is the ability of private insurance holders to "queue jump," in other words not having to wait on an NHS waiting list for elective procedures.

[14] This measure was one of the promises contained in the 1979 Conservative Party manifesto.

worth £30 million in lost taxes for the Government (Pearson, 1992, p. 222). The extension of private insurance to a wider segment of the population was not necessarily beneficial to insurers as they soon saw claims increase more quickly than premiums. This was particularly true of company plans (Allsop, 1995, p. 162). In 1990, the Government introduced a further tax measure geared towards the elderly, particularly those who retired from companies which offered private health insurance to their employees. Because of its impact on the Government's revenues this measure was originally fought by the Chancellor but in the end the Prime Minister prevailed (Allsop, 1995, p. 162; Pearson, 1992, p. 223; Lawson, 1992, p. 616; Thatcher, 1993, pp. 612-613). This event shows that the Government's fiscal considerations could be set aside in favour of ideologically motivated policies.

Clues as to why the Thatcher government was so keen on encouraging private sector health insurance come from two sources. The 1983 Party manifesto stated that private insurance would benefit the NHS as it "lightened the load on the NHS" and private health care - through insurance - would act as a "supplement to state care" (Conservative Party, 1983, p. 28). As far as Mrs Thatcher herself was concerned private health insurance was a measure which would divert "all the extra demands" of an ageing population from the NHS to the private sector (Thatcher, 1993, pp. 612-613). It is clear that the Government saw encouraging private health insurance as a means of reducing public expenditure for health (Lawson, 1992, p. 616). However, this argument fails to capture the consequences on the private sector of dealing with a segment of the population which consumed an inordinately large amount of health care.[15] Private premiums would have to rise and so would the Government's losses of revenue. In the

[15] This issue is analysed in Treasury (1989, p 4).

end 'NHS off loading' can be seen as a very costly proposal. However, this critique notwithstanding, one can see once again the Tory government's underlying concern with the size of public expenditure, as well as its ideological orientation towards reducing the ambit of state provision, as central to its policies in relation to private insurance.

In 1982 the Central Policy Review Staff prepared a report calling for the conversion of the NHS from a publicly financed health system to a private, mandatory, 'all-insurance' system not unlike that found in some continental European nations. News of the report caused an uproar in cabinet and its recommendations were shelved. However, while the CPRS's vision was perhaps too radical for the Government to contemplate, this is not to say that the Government did not toy with other ideas aimed at modifying the financial basis of the system - including a greater reliance on private insurance - as a means of controlling the expenditure on the NHS. It is to these issues that I now turn.

One of the issues explored in this research is that of the limits - either institutional or political - which stand in the way of wide ranging reforms of Medicare or the NHS. This focus hopes to inform a discussion of Therborn and Roebroek's (1986) irreversibility thesis. This issue is relevant to the 1982 funding reform proposals made by the CPRS pertaining to the funding of the NHS.

The CPRS proposals were discussed at a September 1982 cabinet meeting. The paper, which followed a Treasury initiated survey of public spending trends (Economist, 18 September 1982; Economist, 9 October 1982; Lawson, 1992, p. 303), [16] proposed altering the NHS' funding regime by replacing Government funding with mandatory private health insurance. It was expected that such a change would result in savings of up

[16] In her memoirs Margaret Thatcher minimizes the role of Cabinet in commissioning the CPRS paper by indicating that it was produced jointly with the Treasury forecast (Thatcher, 1993, p. 277).

to £4 billion in the 1982-1983 health budget. Among other changes the CPRS paper also proposed increases in prescription charges and instituting charges for visits to the doctor (Economist, 18 September 1982; Observer, 19 September 1982).

The CPRS proposals caused a "riot in cabinet"[17] (Lawson, 1992, p. 303) with 'wets' lining up against the measures proposed. For her part the Prime Minister claimed to have been "horrified" by the CPRS paper and that its options had never really been given serious consideration by ministers "or by me" (Thatcher, 1993, p. 277). The leak of the CPRS proposals, coming close to the 1982 Conservative Party conference, forced the Government into a damage control exercise (Economist, 9 October 1982).

This episode highlights a desire on the part of the Government to seek radical solutions to its fiscal problems, solutions which it knew would face strong political opposition. Moreover, the proposals joined together two essential aspects of Tory thinking at the time, promoting self-reliance and controlling public spending.

In the end the CPRS proposals were not retained firstly, because the proposals did not meet with overwhelming support from the private health insurance companies (the expected natural supporters of such a recourse). Throughout the 1979 - 1990 period private insurance firms would have a schizophrenic relationship with their business - on the one hand enjoying the new business which came their way as a result of government policy, but on the other concerned about the "bad risks," which this widening of their clientele entailed (Döhler, 1991, p. 258). The possibility that the private insurance sector would suddenly have to accept all comers, rather than cream-off the best clients, was one which concerned the private insurers.

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[17] This Cabinet meeting is described in some detail in *The Economist* (9 October 1982).

Secondly, and more importantly, the CPRS proposals were rejected because they ran against the grain of the political and social consensus surrounding the NHS - the "supportive consensus." A switch to a privately driven health insurance system would mark a break with the 'collectivist' or progressive nature of the NHS' existing funding formula where, with the exception of fairly small NI contributions, no direct financial link existed between the user of the NHS and its provision. Funded mostly out of taxes, the NHS' formula had created a buffer between the service and its cost for most users. Creating a system whereby premiums needed to be paid would eliminate this politically and socially convenient separation. Moreover there existed little desire in 1987 on the part of Britons for radical changes to the NHS; quite the contrary in fact (Bosanquet, 1988). This would have been no different in 1982. The decision to shelve the CPRS proposals was an affirmation by the Thatcher government of the NHS' centrality to British political culture and a realization that to challenge this meant political difficulty down the line. It is no coincidence that the 1982 Conservative Party Conference was used as an opportunity to reaffirm the Government's support for the NHS and that the 1983 election manifesto explicitly pledged to guard the NHS. After 1982 the NHS became "safe with us" (Döhler, 1991, p. 257). The CPRS document making this pledge both necessary and expedient. Thus, protected by public opinion - and by politicians aware of public opinion[18] - the NHS was, more than ever, an irreversible part of the welfare state.

[18] Döhler (1991, p. 257) adds that it should not be construed from the 1982 episode that the Thatcher government was always responsive to public opinion, as can be seen in the Government's decision to phase in the contracting out of services in spite of public opposition.

5.4 Summary and observations

The two preceding sections are illustrative some of the themes which are at the heart of this research. In terms of New Right preferences both the CPRS proposals and the decisions regarding the funding of the NHS show a similar pattern. In both cases the New Right proclivity to prefer solutions that favoured individual self-reliance is evident. Increased charges made individuals financially responsible for their health care, as would to an even greater degree a switch to a premium based health insurance plan. Both measures, however, were constrained by inherited policy.

Although the Thatcher government possessed the policy tools necessary to change policy, for example, through increases in charges or the elimination of exemptions, this was not pursued because of the constraints placed upon its policy making by approximately forty years of British government policy. This raises the importance of path dependency in the determination of governmental policies and objectives. Related to this last point, and as I have discussed at length above, this path dependency, or inherited policy, was reinforced by a supportive consensus attached to the NHS. This raises limitations inherent in my institutionalist model. In this case, a strong state having at its disposal the necessary policy instruments is constrained by factors extraneous to its institutions. One way around this problem is to consider, as Hall (1992) does, this path dependency as part of the panoply of informal "standard operating procedures" of the state. In this sense, path dependency is the consequence of the institutionalization of anterior policy decisions. However, keeping in mind Thelen and Steinmo's (1992) caution that institutions are seldom the sole explanation for political events, whatever limitation posed by the preceding discussion to my institutional argument highlights my

overall contention that the analysis of policy change in health is subject to multi-factoral explanations, of which institutionalism is but one aspect.

Finally, in the case of the NHS charges, the incrementalist model, particularly budgetary incrementalism as described by Wildavsky (1964), appears to capture the nature of the policy process. Over the period in question there were no massive changes in NHS charges and even when the sums involved did increase substantially a whole category of individuals were exempted. In this case it appears that the Thatcher government was proceeding on the basis of incremental change.

5.5 *Working for Patients* and the Internal Market reforms

The different policy strands described above came together in the 1989 White Paper *Working for Patients.* Elements familiar to other policy drives, such as improving services to consumers, improving provider accountability, and improving general system efficiency were to be in evidence as part of the IM reforms. The wider elements of the Conservative agenda, elements such as weakening professional power and instituting marketplace style management, accountability and competition, for example, are also in evidence as underlying themes. Of course the genesis of the 1990 reforms is also linked with the twin goals of fostering greater 'value for money' from the Service and reducing pressure on the public purse. As one respondent said, "The UK Government has genuinely wanted to make the best use of available public sector resources, not just reduce the pressure on public expenditure but to do a better job of work. This, ..., is what suffused the NHS review" (Personal interview GB 5).

In terms of this comparative study the Internal Market (IM) is important as it represents the type of radical policy change which is institutionally impossible for the Canadian government to initiate.

5.5.1 Origins of the review and ideas

Radaelli (1995, p. 176) suggests that when a policy sector is in crisis it is more permeable to "'ideas in good currency.'" This is perhaps a good description of the manner in which the IM became the chosen policy of the Thatcher government in 1989.

In her memoirs Margaret Thatcher states that had she been able to recreate the NHS she would have allowed for a bigger role for the private sector and changed the basis of financing to include sources other than general taxation. The Government, however, was not working from an empty slate. While the NHS had evident problems, it was also a cherished institution[19] and "[any] reforms [could] not undermine public confidence" (Thatcher, 1993, p. 607). This is not to say that the Government was not willing to reconsider the shape of the NHS. Again according to Thatcher, discussions on this topic were held as early as the summer of 1986 and in January 1987. This was a period when many ideas about the future of the NHS were being discussed both inside and outside government. As far as the Prime Minister was concerned, however, the main issues which needed to be addressed were the relationship between "the demand for health care, its cost, and the method for paying for it" as well as how money was allocated within the NHS (Thatcher, 1993, p. 607). These discussions continued until 1987 with the new Secretary of State at the DHSS, John Moore who "was very keen on a fundamental review" (Thatcher, 1993, p. 607). By this point in time the Prime Minister

[19] Lawson (1992, p. 613) states this more strongly in his statement that the NHS "is the closest thing the English have to a religion." See also Bosanquet (1988).

had become concerned with improving the efficiency of the NHS and generating better value for money, leading her to conclude that what was needed was "a proper long-term review" (Thatcher, 1993, p. 608).[20] But while the Prime Minister was becoming increasingly convinced of the need for a review the NHS, two events propelled the review forward. The first was a joint declaration by the heads of the Royal Colleges of Physicians and Surgeons and Obstetricians and Gynaecologists criticizing the Government's NHS funding decisions (Independent, 7 December 1987), and the second was the media portrayals of consequences of resource shortages in the hospital sector (personal interviews, GB 4; GB 6; GB 1). Reacting to these charges and reports Mrs Thatcher announced the establishment of the Ministerial Review of the NHS on the BBC's *Panorama* on 25 January 1988 (Independent, 26 January 1988). However, even before the review was struck its conclusions had already been outlined. For example, Mrs Thatcher in an October 1987 interview to *The Independent* stated both her intention to initiate a review and her preference for the introduction within the NHS of an internal market system similar to that which had been introduced in education (Independent, 5 October 1987). John Moore would echo Thatcher's preference for the creation of an internal market in his speech to the Conservative Party conference on 8 October 1987. Moore, however, took a harder line than the Prime Minister on the review which he saw as creating the opportunity for a wide-ranging alteration of the NHS. In his speech Moore would state his hope that "'sacred cows' would be swept away [and that] outdated

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[20] Nigel Lawson in his own memoirs describes the events leading up to the decision to set up the Ministerial Review somewhat differently. Not surprisingly, Lawson appears to cast himself in the lead role as he describes a pre-Budget meeting held between the Downing Street neighbours where he discussed at length the need to review the NHS. Having set out his argument, "Margaret appeared to agree." Later, upon informing John Moore of the news that the Prime Minister seemed to be backing a full-scale review of the NHS he found his ministerial colleague "delighted." While Moore had strongly supported the creation of such a review, Lawson writes, "she [the Prime Minister] had firmly warned him [Moore] against it" (Lawson, 1992, p. 614).

ideologies would not be allowed to stand in the way of change." On Moore's agenda for change was the extension of private sector provision of ancillary services and allowing hospitals to move into profit making enterprises (Independent, 9 October 1987).

The Ministerial Review Committee was chaired by the Prime Minister and included Nigel Lawson (Exchequer), John Major (Treasury), John Moore (Social Security), Peter Walker (Welsh Office), Malcolm Rifkind (Scottish Office), and Tony Newton (Health Minister). Kenneth Clarke would join the committee upon his appointment as Secretary of State for Health in the summer of 1988, as did David Mellor when he replaced Tony Newton as Minister of Health. These last changes in the individuals who took part in the Review is of significance to the outcome of the Review as it was known that Kenneth Clarke was more favourably disposed towards the existing principles of the NHS than John Moore (Griggs, 1991, p. 424; Lawson, 1992, p. 615). Roy Griffiths was also invited to take part in the deliberations of the Review, as did John O'Sullivan from the No. 10 Policy Unit (Griggs, 1991, p. 424; Lawson, 1992, p. 165). The work of the Review itself was supported by officials from the Downing Street Policy Unit, the Cabinet Office, the DHSS/DoH[21] and Treasury. Within the DHSS/DoH a small team of officials were responsible for preparing the policy papers which were then distributed by the Cabinet Office (personal interviews GB 5; GB 4; Griggs, 1991, p. 424).

From the start the Ministerial Review was determined to explore a wide array of options. Thus, as press and other reports on the period highlight, it appeared that no area was considered too 'sacred' for investigation. Despite its broad spectrum, certain limits to

[21] In November 1988 an administrative decision was taken to split the DHSS into two departments, Social Security and Health. This was done partly due to the differences in the two remits of the DHSS and partly to unburden the Ministers (personal interview GB 4).

the Review's work did exist. These can be seen in the principles which Mrs Thatcher set for its outcome:

> First, there must be a high standard of medical care available to all, regardless of income. Second, the arrangements agreed must be such as to give the users of health services, whether in the private or public sectors, the greatest possible choice. Third, any changes must be made in such a way that they led to genuine improvements in health care, not just to higher incomes for those working in the Health Service. Fourth, responsibility, whether for medical decisions or budgets, should be exercised at the lowest appropriate level closest to the patient (Thatcher, 1993, p. 609).

"Medical care," the Prime Minister further stated, "should continue to be readily available to all who needed it and free at the point of consumption" (Thatcher, 1993, p. 609). The background papers commissioned by the Review considered issues such as consultant's contracts, financial information, efficiency audits, waiting times, and the scope for increased charging (Thatcher, 1993, p. 609). Nigel Lawson and the Treasury were particularly vocal in pushing for the extension of NHS charges. Thatcher, however, feared the political storm that increased NHS charges would unleash and vetoed such change (Lawson, 1992, p. 616; Thatcher, 1993, p. 609). This reaction was not unlike that which was encountered when the CPRS' reform proposals were brought before Cabinet in 1982, and the decision to quell these options was founded upon the same political constraints. From Mrs Thatcher's memoirs it is possible to see that the reforms proposed and implemented were path dependent, that is, a succession of decisions ranging back to 1948 had established a series of policies and principles which had become institutionalized both politically and socially. Any policies emerging from the Review therefore had to be consistent with previous policy or in breaking with the policy path of the previous forty years the Government exposed itself to political risk.

A policy paper requested by John Moore set out a number of routes for NHS reform. This paper would posit the first great issue to be faced by the Review: that is the issue of finance. Two approaches were considered: either replacing the tax-based system by a contributory (social) insurance based system, or creating incentives for individuals to take out private insurance coverage. The proposal championed by Moore would have seen the replacement of tax-financing by a social insurance based financing. This, it was judged, would foster a greater awareness among individuals of the costs of the NHS and would have permitted opting out[22] (Thatcher, 1993, p. 610). The DoH undertook a study of the social insurance model which considered the experience of other countries but, in the end, a political decision was taken that changing the financial basis of the NHS was not a desirable option. The issue of social insurance for health was shelved (personal interview GB 5). What is interesting, however, from this episode is that a second attempt was made to change the financial foundations of the NHS. This either shows that the Thatcher government had failed in learning from the 1982 episode, or that it was felt among some individuals around the review table - Moore undoubtedly among them - that a policy window existed which made a radical policy departure possible. However, if there existed such a window it was rapidly slammed shut by Mrs Thatcher.

Part of the Review's discussion of financing concerned the place of the private sector, particularly private insurance within the wider health care system. Mrs Thatcher was a believer not only in the recourse to private health insurance but also in its beneficial effect on overall health expenditure, especially for groups such as the elderly. The Review thus proposed ways of facilitating the take-up of private insurance and these were

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[22] This was not a new or unique idea. In 1988 Leon Brittan proposed a system of social insurance for health with opt outs, but this was not taken up by the Government. Moore's proposal would have incorporated Brittan's' plans (Butler, 1992, pp. 7-8).

adopted in the face of strong opposition from Lawson and the Treasury (Thatcher, 1993, pp. 612-613; Lawson, 1992, p. 616). The changes were announced as part of the 1989 Budget (Hansard, 14 March 1989, c.407).

It is only after the issue of financing had been set aside by the Prime Minister that the work of the Review turned to the structural reform of the NHS which culminated in the IM proposals.

Radaelli (1995) notes that individuals are important in tracing the history of a policy proposal. In this instance that individual could be said to be Alan Enthoven. Enthoven's contribution to the discussions about the future of the NHS were published in a 1985 monograph entitled *Reflections on the management of the National Health Service* (Enthoven, 1985).[23] In its pages Enthoven outlines a system similar to the American Health Maintenance Organization (HMO) model. From this HMO model would be derived the model proposed by the White Paper. According to Enthoven an internal market for health care would foster efficiency as patients would flow to treatment units which were necessarily better, both in terms of cost and quality of care. Enthoven's proposals attracted attention from *The Economist* where, it is reputed, Mrs Thatcher first became aware of the concept of the IM (Allsop, 1995, p. 168, citing David Willetts). Mrs Thatcher, for her part, states that she had held talks in 1986 with Norman Fowler where reform of the NHS including 'money following patients' - the basic element in Enthoven's plan - was her preferred choice of action (Thatcher, 1993, pp. 571, 607). It is further true that internal markets existed in many areas of British public administration well before Enthoven's paper. Enthoven himself would remark that while the final version of the IM outlined in the White Paper bore some resemblance to his idea, it

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[23] In a later article (1991) Enthoven offered his evaluation of the Government's NHS reforms.

needed "to be worked out in more detail" (BMJ, 29 April 1989; Enthoven, 1991). In short, Enthoven accepted paternity for the idea but not for its evolution.[24]

It is interesting to pause here and consider the manner in which the Ministerial Review was conducted. One of the persistent anecdotes concerning the Review was that it was a largely closed process open to very few outside interests (Griggs, 1991; Allsop, 1995; Pearson, 1992; Klein, 1995; Pihan and Curtice, 1994; personal interviews GB all). Moreover, rather than pool opinions from outside interests, particularly the traditional health interest groups (the BMA for example), the Committee shied away from outside consultation, with the possible exception of groups and individuals from the New Right (Griggs, 1991, p. 426). However, even for these groups the process was not wide open since their participation can be said to have been made on invitation only (Pihan and Curtice, 1994). Griggs goes further and states that a strong competition existed among New Right think tanks regarding who would influence the outcome of the deliberations. Among these groups Griggs identifies the Centre for Policy Studies (CPS), which he suggests had the most influence on the Committee, the IEA Health Unit, and the Adam Smith Institute. Surprisingly, the Conservative Party's own Research Department was not consulted and in fact issued a discussion paper critical of the IM (Griggs, 1991, p. 426). However, although these New Right think tanks are described as influential to the Review, as late as May 1988 the Adam Smith Institute and the CPS were still looking on from the outside. Appearing before the Social Services Committee in May 1988, representatives[25] from the CPS and the Adam Smith Institute indicated that while both

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[24] Enthoven was also critical of the fact that the Government had opted not to 'pilot test' its plans, and noted: "I saw many very good ideas, but I also found it hard to see just how the government's proposals would work in practice." Enthoven was also critical of the Government's decision to offer tax relief for health insurance which he says "had been a disaster in the [US]" (BMJ, 29 April 1989).

[25] These were: David Willets and Dr Michael Goldsmith from the CPS and Dr Eamonn Butler and Dr M Pirie from the Adam Smith Institute.

had been keen to contribute to the Review, neither group had been invited to participate in its work or "appear" before it. The Adam Smith Institute had contributed a brief which it had sent to the Secretaries of State at the DoH and Treasury as well as the Downing Street Policy Unit. The CPS had not prepared a brief[26] (Social Services Committee, 1988b, p. 172).

The experience of these two groups is not unlike that faced by others such as the BMA, the trade unions, and health sector NGOs (personal interviews GB 1, GB 3, GB 8, GB 9). Furthermore, as the Government chose to go directly to the White Paper stage, rather than the usual Green Paper or consultation paper, its plans appeared set in stone. Suffice to say on this issue that the Government's no-consultation strategy was designed, in the words of Klein (1989, p. 237), "... to produce policy options for the Prime Minister not a public consensus about the NHS." In that sense one is reminded of the 1983 Griffiths Inquiry which also focused on achieving recommendations quickly, rather than examining issues to their fullest.

The no-consultation strategy observed by the Government had another advantage. Pihan and Curtice cite Kenneth Clarke's view that a consultation exercise would only have provided a platform for opposition to the Government's plans, not informed discussion: "What always happens with public consultation is that you give an ideal platform for opponents and it is difficult for supporters to come forward ..." (Pihan and Curtice, 1994, p. 11).

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[26] This is interesting to contrast with Griggs' statement that the CPS was one of the most influential groups in putting forward options for the work of the Review.

5.5.2 Aims of the policy

In order to understand the aims which were pursued by the Thatcher government with *Working for Patients* it is useful to retrace some of the developments which I described above. Although there is no evidence of a deliberate policy chain, it is nonetheless true that the many initiatives which were put in place between 1979 and 1989 were thematically linked. This thematic link being the quest for the best 'value for money.' From this goal flows all others.

Butler (1992, pp. 33-34), for example, argues that the purchaser provider split in the Health Service was but a more advanced version of the original drive for the NHS to contract out ancillary services. Similarly, the creation of hospital trusts is an evolution of the earlier policy pursued in education which sought to encourage schools to opt out of their Local Education Authority (LEA). Or one can trace the root of the concept of the trust hospital further to the pre-NHS era voluntary hospitals (Butler, 1992, p. 48). That Mrs Thatcher seemed convinced of the viability of an 'internal market' as a solution to the perceived problems of the NHS well before the Ministerial Review was struck further re-enforces this suggestion of a thematic link. Put another way, the IM - tried as it had been in other sectors of public policy such as education - was *the* solution in search of a problem, in this instance the state of the NHS (personal interview GB 8).

According to Kenneth Clarke the fundamental aim pursued by the Government was "to make the Health Service more responsive to the needs of patients" (Hansard, 21 March 1989, cw. 563). But while the underlying rhetoric of "money following patients" was improved service, it was also part of the larger Tory policies aimed at improving the general efficiency of public services (Allsop, 1995, p. 169). After years of forcing the NHS to cope with efficiency savings the Government was now ready to try a more radical

operation. Placing the benefits of the reform squarely in terms of the efficiency savings it would generate, Clarke stated that,

> [the proposals] are designed to ensure that all parts of the [NHS] offer the best possible service to patients. The better value for money obtained under the new system will itself ensure an increase in levels of patient care... (Hansard, 23 March 1989, cw. 563).

The results of the Review were eminently pragmatic and steered well away from the type of American individualistic solutions which it was thought Mrs Thatcher tended to prefer (Holiday, 1992, p. 46; personal interview GB 8). In fact, in her Foreword to *Working for Patients* the Prime Minister reaffirmed the founding principles of the NHS. The NHS, "will continue to be available to all, regardless of income, and to be financed mainly out of general taxation" (DoH, 1989, p. 1). This was a recognition of the limits to which her policies would be acceptable to the population.

In short, in line with a desire to put the interests of patients first, and increasing consumer choice and decentralization, the White Paper proposed the division of health services between providers and purchasers. Seven major measures were proposed to achieve these goals. These were:

1. The moving of the level of accountability to the local level with the RHAs' main role being to ensure that the Government's policies were effectively carried out.

2. Hospitals that met a certain criteria would be encouraged to become self-supporting Trusts. The main advantage of this status would be to permit them to redraw all their contractual obligations, including wage contracts. Trusts would operate as independent enterprises whose clients would be the DHAs.

3. The establishment of a system whereby funds would follow patients, in effect meaning that one Health Authority would charge another for services 'purchased.'

4. GPs who were part of practices with over 11,500 patients would be able to become fundholders. These would administer, i.e. spend, their own budgets for purchasing hospital services, in effect, taking over the role of the health authority.

5. The Health Authorities would be replaced with smaller management bodies in line with the general management advocated by Griffiths.

6. The Audit Commission would be responsible for auditing the quality of service and expenditures of the NHS.

7. In an attempt to deal with what had often been a lightning rod for criticisms of the NHS, the Government moved to increase the number of consultants, hoping this would reduce the length of waiting lists (DoH, 1989; Pearson, 1992, pp. 239-240; Holiday, 1992, pp. 45-57; Klein and Day, 1990; Hansard, 21 March 1989, cw. 563).

Thus the White Paper was a mixed bag, pulling together the Thatcher government's impulsive, pro-competitive objectives, yet also the various departmental initiatives (such as medical audit) which had been simmering in one form or another throughout the 1980s (Paton, 1993, p. 87).

The case for and against the proposals set forward in the White Paper and subsequent legislation revolves around the issue of whether the IM was simply a management 'gimmick' that left the essence of the NHS unaltered as opposed to a genuine departure from previous policy. As with most policies the reality is somewhere in the middle. It is true that much of what was proposed in *Working for Patients* was essentially geared towards the administrative workings of the NHS - much as Griffiths has done in 1983. For the average consumer of NHS services there was to be little real change. Their relationship with the Service would still begin at the GPs office and as far as pocket book issues were concerned the NHS continued as it had since 1948 - largely free, universal, and comprehensive. However, to use a motoring metaphor, if the bodywork of the new NHS seemed the same as previous years, the engineering under the bonnet had undergone a significant overhaul.

How were these changes radical policy departures? Firstly, the 1990 reforms required a change in both the structure of accountability of the Health Service and how it

was to be funded. Thus, in the implementation phase a clear chain of command was established which ran from the Secretary of State through to the units. At each level in this chain were to be found empowered managers who would be "responsive to the political pressures that were driving the change" (Butler, 1992, p. 36). At the centre the Government proposed to establish a strengthened operational branch through the NHSE. Away from the centre the RHAs, DHAs and family practitioner committees (FPC) were changed to enable them to act decisively as agents of the centre. To do so the composition of these bodies was reduced to ten members. Membership would be through appointment by the Secretary of State and doctors and nurses would lose their guarantee of representation. As Butler notes, "with these changes the NHS acquired a management culture of command and obedience" (Butler, 1992, p. 36). However, if implementation required command and control it was hoped that once in operation the IM would operate through contractual links rather than operational ones. Related to these changes was a move away from the RAWP formula for funding to one based exclusively on the size of the resident population (Klein, 1995, p. 207).

One can see in these changes a quite strong move away from the previous model of NHS administration and policy. Firstly, by shifting the levels of authority the proposals in effect altered the configuration of the NHS' power centres - these would move towards the centre, with all other levels of services becoming merely operational tools. Thus, rather that improving consumer responsiveness at the level closest to its users, the reforms in effect determined that the centre would decide what was the wish of consumers at the unit level. This, in conjunction with the move away from RAWP, would also come to effect the distribution and control over resources in the NHS. Additionally, the recomposition of the local boards meant reducing the role of provider

interests as well as local representative interests in defining Health Service priorities. With regards to the medical profession and nurses, this was the second blow to their participation in health policy, the first occurring as a result of the Griffiths Reforms.

The proposals to create hospital trusts, fundholding GPs and the principle of money following patients are also illustrative of a major change in policy. Control over resources is often one of the best indicators of power where public policies are concerned. In this instance all three of these policy alternatives had the effect of changing the allocation of financial resources and with it re-drawing the relations of power among NHS participants. Interestingly, however, although the Government vowed to improve consumer choice - none of the changes driven by *Working for Patient* transferred control of financial decisions to consumers themselves. Rather the control of resources was shifted among new or different arrangements of agents that had been the case in the past.

With the reforms resource allocations would change and with it a whole slew of relationships within the NHS. GP fundholding for example gave a certain class of GPs greater operational autonomy from the NHS' administrative structure than they had in the past. As a result the relationship between GPs and consultants, for example, changed significantly. Rather than the GP being simply a gatekeeper to a wider health system where consultants made all the important and costly decisions - fundholding shifted power to GPs as it was they who now determined which consultant and which hospital would get their referral and therefore a slice of their fundholding budget. Consultants who in the past may have treated their GP counterparts with some indifference were forced to bring-in GPs more greatly into the treatment sequence. These changes were mirrored in the hospital sector where trusts would be able to compete on health services, costs and additional non-medical perks. This was forced by a new competition with

private hospitals to which fundholding GPs or DHAs were now permitted to refer patients - as well as new competition from hospitals which remained in DHA control. Furthermore, the old structures of interests were also changed by these reforms as divisions occurred between fundholding and non-fundholding GPs and administrators from trust and non-trust hospitals. As each began to interpret the IM along their own cost-benefit calculations what had been the traditional pattern of health interest group relationships and representation was reshaped and redrawn to mirror the new division of power and authority within the NHS.

While many of the other reforms brought forward by the Government prior to 1989 also altered these foundations those that flowed from the White Paper were the most profound in changing the inner workings of the NHS. However, the IM reforms also showed the Thatcher government at its most pragmatic for by neither changing the method of funding nor the basic principles of the NHS it limited its exposure to criticism. In this case the loudest critiques were those levied by provider interests.

5.5.3 Implementation

Mrs Thatcher, the driving force behind the Review and the legislating of the IM, would leave office before the implementation phase of the Reforms could be said to have really begun. As such, although she and her government proposed a radical re-design of the NHS, this radicalness needs to be measured not as the IM was proposed but as it has been implemented. The following discussion takes this study beyond the November 1990 cut-off in order to discern, very broadly, if the Reforms of 1990 were as radical in childhood as they appeared at conception.

Commenting on the 1990 Reforms Klein (1995, p. 223) notes that only New Zealand had achieved anywhere near the level of policy change that had occurred in Britain. An achievement which was aided in both countries by their institutional structures and in particular their parliamentary systems. Moreover, the success of the NHS Reforms marked the successful shift of the debate concerning health policy away from providers and to parliamentary actors.

Has the NHS changed? On the surface the NHS continues today as it has since 1948. Searching for signs of post-1990 and its impact prove to be vexing (Robinson and LeGrand cited in Klein, 1995, p. 230-231) and perhaps a better strategy might be to look for lack of change. Thus, for example, although the IM purported to empower consumers this has still to become a reality. Not only are treatments determined by providers but the panoply of services offered by the NHS continues to be the preserve of central and local decision makers and provider interests. Instead of increased services the post-1990 NHS has been marked by the pruning of Health Authorities menu of services (Klein, 1995, p. 232).

However, it is the creation of NHS Trusts and fundholding practices which provides the better indication of the success of the policy. In the period leading to the 1 April 1991 launch of the IM - beginning in fact shortly after the publication of the White Paper - several hundred expressions of interest were received from hospitals and GP practices hoping to be among the first to take advantage of the changes brought about by the Reforms (Butler, 1992, p. 110). By 1994 there were 440 Trusts providing 90 per cent of hospital and community care and about 25 per cent of all GP practices had become fundholders (Allsop, 1994, pp. 180, 185). Therefore, in terms of creating a new structure the Reforms were successful. More difficult is determining if this structure is working

along the quasi-market lines that were expected. Evidence to date shows that rather than the wholesale shift in intra-NHS relationships GPs and DHAs have "tended to remain loyal to the established providers" (Klein, 1995, p. 242). However, the potential for such a shift has empowered purchasers, particularly GPs in their relationship with consultants (Klein, 1995, p. 241).

In short, the reforms of 1990 have achieved a change in the structure of the NHS but it is still some distance from its ultimate goals. However, like Griffiths before it, the IM reforms is significant and radical because - beyond its institutional changes - it has created the potential for further change in the system and changed the mentality of those working within the NHS.

5.5.4 Medical opposition to the Internal Market

The story of the run up and passage of the IM reforms is also the story of a high pitched battle between the Government and the British Medical Association. Essential for this discussion however is an understanding of the nature of the challenge posed to the BMA by the 1990 Reforms. A challenge framed by the doctors as one about the future of the NHS but really one mainly about the medical profession's self-interest in seeking to maximize its economic gains and preserve these in the face of the changes brought about by the IM.

The 1979 to 1990 period marked the low ebb in the relation between the Government and the medical profession as each successive reform of the NHS seemed to the BMA as another challenge to its autonomy and influence and it is undoubtedly true that the changes brought about by Griffiths lessened the overall influence of the

profession over the direction of health policy at the local level (Day and Klein, 1992).[27] To the BMA the IM reforms however represented the greatest challenge yet to the profession and its power.

As noted above, the process of policy development undertaken by the Ministerial Review shut out of the process a number of groups which had traditionally participated in policy-making. None more than the BMA. Confronted, as it was, with a *fait accomplis* the BMA at first responded to the White Paper with a detailed report of its own outlining its vision of the future of the NHS (BMA, 1989). It followed this with a broad canvass of its membership and used the results in its lobbying of government and public representation campaigns.

The next phase in the BMA's strategy was a widespread media and public relations campaign held between February 1989 and July 1990 which included billboard and newspaper advertisements which focused primarily on the issue of the alleged underfunding of the NHS. Despite this public campaign on the part of the BMA the Government held firm, its position since the start of the Ministerial Review having been to avoid collective or consensual decision-making. With legislation pending however it was too late to change the Government's policy.

Although the *Working for Patients* proposals would have a significant effect on the patterns of resource allocation within the NHS as well as the structure of intra-NHS relationships (GPs vis-à-vis consultants for example) it was apparent early on that the BMA's opposition to the White Paper and subsequent legislation was largely based upon the professions self-interest and its opposition to the GP contract which the Government impose on the profession in April 1990 (Ham, 1992, pp. 52, 68; Klein, 1995, pp.

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[27] Outstanding accounts of this period are found in Pihan (1990).

199-201). A process which the head of the BMA's council, John Marks, described as "a contract imposed on [GPs] under the draconian powers" of the Government's legislation (BMA, 1990, p. 3).

The source of the BMA's opposition to the new contract - and subsequently the White Paper - has its roots in the mid-1980s, particularly the publication of the 1987 White Paper *Promoting Better Health* (DHSS, 1987) which outlined a new GP contract which was to be more clearly focused on the GPs role in preventive health care (Klein, 1995, p. 200). Negotiations between the BMA and the Government began in early 1988. When the Ministerial Review was announced the BMA sought Government assurances that the issue of General Practice would not be part of the Review, assurances which it received (personal interview GB 1). Negotiations on the contract continued with the BMA becoming increasingly concerned by the limited consultations which the Review was undertaking. Despite its stated eagerness to participate in the Review the profession was held at arms length - with input from the professsion limited to "doctors who had a political allegiance to fulfil" (personal interview GB 1). Thus, when *Working for Patients* was released contrary to Government assurances not only did it impact on General Practice, it also created a new type of GP - the fundholder (personal interview GB 1; Klein, 1995, pp. 200-202).

The contract at first agreed to by the BMA called for an increase in the percentage of income which GPs would derive from capitation (from 46% to 60%). This was seen by the Government as an incentive for physicians to provide the health services which the patients, as consumers, demanded (Klein, 1995, p. 200) and represented a concession on the part of the Government to the profession (Harrison and Pollitt, 1994, p. 127). Twice the membership of the BMA rejected a compromise contract and in April 1990 the

Government imposed a new contract on GPs. The state of the medical profession's negotiations with the Government and the publication of *Working for Patients* intermingled to define the BMA's position to the overall reforms. As Klein states, "it would be futile to try to disentangle the reasons for GP opposition from those which led the medical profession as a whole to battle against the NHS reforms" (1995, p. 201).

Although the BMA's opposition to the White Paper focused primarily an issue of its impact on the doctor-patient relationship and the overall state of the NHS, financial considerations (in the form of opposition to the 1990 contract) were at the heart of the GP opposition to the Reforms. However, as Finer (1958) makes clear, internal cohesion is essential to the success of a lobbying strategy. In this case there is anecdotal evidence that many GPs, in contrast to the BMA's official position, were eager to become fundholders, thus, undermining the strength of the BMA's lobby. In addition, the Government undermined the strength of the BMA's opposition by making agreements with the Royal Colleges - much as Bevan had done in 1946. Overall, while the new contract did not please the profession, it did increase its income. "Militancy was doused by prosperity" (Klein, 1995, p. 201) raising the question of how vociferous would the BMA's opposition to the IM have been had a GP contract acceptable to the profession been in place before the policy drive.

Although the BMA continued to case its opposition to the IM as about the future of the NHS, for example in opposing the creation of Trusts and purchasing contracts without prior pilot tests (BMA, 1990, p. 3) it is clear that it feared for its future as viable interlocutor and representative for the medical profession. For example, Dr. John Marks, BMA Council Chairperson, remarked that "... the mind boggles at what the secretary of state (sic) might do in the future if the present enabling bill [...] becomes an act (sic)

without substantial amendment" (BMA, 1990, p. 3). In the eyes of the BMA this was a crucible for the future role of medicine in policy making in the NHS.

Once outside the policy arena the BMA has found it difficult to make its views heard by functionaries and politicians (personal interview GB 1). Paradoxically, although the reforms pushed aside the medical profession, a growing body of anecdotal evidence suggests that physicians may be regaining some lost ground during the implementation phase of the IM (Klein, 1995, p. 241). Moreover, as I noted above, the change in the relationship between NHS actors created by the purchaser - provider split may have also contributed to a shift in the power base of medicine away from hospital based consultants towards GPs. The profession may no longer have a much constitutional power as in the past but in exchange it may have gained distributional power (Day and Klein, 1992).

5.5.5 Summary and observations

Döhler (1991, p. 266) writes that "[the] review process, ... , was a vivid confirmation of ... the ability of the British central government to employ a powerful set of policy instruments." This statement concurs with my own reading of the episode of the IM. The very premise under which the Ministerial Review was established gives a strong indication of the ability of the British state to make policy. In this instance the outcome of the Review points to its ability to 'do something.' Constrained by politics *Working for Patients* was "halfway radical and halfway moderate" (Döhler, 1991, p. 266). It is radical in so far as it restructured the internal operations and relationships within the NHS. The concept of 'money following patients' is one that was revolutionary for the NHS - although it must be recalled the IM had a trial run in other sectors. Although it preserved the principles of the NHS - as far as users were concerned NHS services were

still free, it was still tax financed, and the institutions that comprised the NHS remained publicly owned. Undoubtedly, the Thatcher government could have been far more radical in pursuit of its New Right principles. Potential policy options open to it included the complete dismantling - save but for a small residual service for the poor - of the NHS or change along the lines proposed by the CPRS in 1982. It is in this sense that Döhler's comment that the IM was "halfway radical" should be read. Analysis cannot look too far to the ultimate extension of a policy. Thus, in this case because the truly radical option was the dismantling of the NHS, the fact that it was administratively reformed doesn't mean that the Reforms were not radical. Considering the changes in the intra-NHS relationships and resource allocations brought about by the IM one cannot but conclude that the change was radical - even if it did not reach as far as the Government's New Right idiom might have indicated. In one sense the IM for health was almost the perfect policy option for the Thatcher government to espouse, for it allowed at once the pursuit of the radical change that its New Right philosophy (market principles, expenditure control, and value for money) called for while still maintaining intact a cornerstone of the British welfare state. The IM also showed the Thatcher government to be a pragmatic political player, none too concerned with ideological purity at the expense of political considerations. In this sense the IM showed the Thatcher government to be both middle-ground in its approach to this part of the welfare state - as had the Post-War Conservative administrations - and consistent with the party's statecraft through the pursuit of power.

Thus, the creation of the IM highlights the institutional argument which underlies this study as well as pointing to an attempt to bring the agenda of the New Right to yet another area of the public policy. As a policy making exercise the Ministerial Review

shows the Government to have operated in a non-incremental fashion. Lindblom's (1959) incrementalist theory therefore leaves us with a gap in explaining the appearance of the IM. Moreover, it is clear that from the outset the Review team was geared towards a major departure - this can be gleaned from Mrs Thatcher's intimation that an internal market would be the likely outcome of the review - rather than incremental adjustment of the Service. In this instance incrementalism is not the best model from which to explain the creation of the IM.

5.6 Unions and group coalitions

I described above the opposition of the BMA to the IM reforms and cast these primarily in terms of the medical profession's economic self-interest. In this sense the BMA could be said to have been acting very much like the more traditional NHS unions such as COHSE.[28] However, if the BMA and the NHS' trade unions could be said to share similar self-interested economic goals they could not be described as allies in opposition to the Government in matters of health policy. The same could be said of the various interest groups and associations which militate on behalf of particular programmes, persons or institutions. One of the striking differences between the Canadian and British cases lies here. While in Canada coalitions formed, before and after the election of the Mulroney government, to lobby for change in policy, in Britain there appears at first glance to be an absence of such coalitions - certainly among the large groups such as the BMA, community health groups and unions. This section will broadly discuss the participation of interest groups in development of the Thatcher government's health policies. In terms of this comparative study this section primarily

[28] Now part of UNISON.

sets the groundwork for my later discussion of Canadian interest group coalitions in the health sector. The existence of such groupings being one element explaining the relative inaction of the Mulroney government's health policies.

Central to the Government's stance towards interest groups was its desire to curb trade union strength. This was particularly the case in health where the trade unions were seen as too powerful and responsible for many of the shortcomings of the NHS. In addition, the militancy of the NHS trade unions (they were key actors during the 'winter of discontent') made them particular targets of Tory industrial relations policy (personal interview GB 9; Harrison and Pollitt, 1994, pp. 61-66). There were of course other actors in the health area, for example the non-governmental organizations. These had a relationship with government which differed from the unions and the medical profession as they were neither working for the NHS nor providers. In these terms the NGOs could have served as a useful middle actor had the Government opted to enlist their support for its policies, particularly when these targeted the providers (e.g. doctors) and/or unions.

Overall the interest group community does not appear to have had much influence on the shape of the Thatcher government's NHS policies. While consultation on various reports and initiatives was generally sought by the Government, the impact which NGO interventions had on the outcome of health policy appeared fairly minimal. Moreover, throughout the 1980s the NGO community saw the quality of its contributions increasingly dictated by the constraints of time imposed on it by the DoH. Thus, while groups had in the past been given large amounts of time to work on their responses to proposed initiatives, throughout the decade this period shrunk dramatically. A turn-around time of weeks became, by the late 1980s, days. To some in the NGO community this appeared to be a sign that the directions of policy had already been

determined. In short, the Government's consultation strategy was largely one concerned with "optics" (personal interview GB 3). Moreover, it is obvious that exercises such as the Griffiths Inquiry and the Ministerial Review offered limited opportunity for input from interest groups outside the Government or the NHS (personal interviews GB 2; GB 3; GB 8).

The relationship of the trade unions with the Government was fraught from the very start. In their discussion of the British policy style Jordan and Richardson (1982) note the existence of a quasi-corporatist relationship between the Government, business, and labour in the negotiation and development of broad macro-economic policies. Consensus seemed to be the *modus operandi* of the British political system and this 'tripartism,' as Jordan and Richardson term this relationship, persisted into the first years of the Thatcher regime. What this model implied was the recognition by the Government of the veto-power of the actors involved. However, early in Thatcher's first term there were already signs that this negotiated style of economic management was at an end (Jordan and Richardson, 1982, pp. 96, 106). Moreover, considering the clear manifesto pledges made to curb trade union power any other outcome but a steady reduction in 'tripartism' would have been surprising. Furthermore, if the 1979 manifesto pledged to reduce trade union influence, the 1983 and 1987 manifestos trumpeted the achievements in this regard and promised yet more challenges to union obstructionism (Conservative Party, 1979; Conservative Party, 1983; Conservative Party, 1987). With regards to the NHS, a consistent theme in the Government's discourse was that the unions were at the heart of many of the problems which plagued the NHS. Moreover, their association with the Labour Party made them and their intentions suspect. As such, a number of policies

were pursued throughout the Thatcher regime to try and weaken the 'power' and 'influence' of the Health Service unions.

The membership of NHS trade unions was divided among the traditional unions such as the Confederation of Health Service Employees (COHSE) and quasi-professional bodies such as the Royal College of Nursing. The membership of COHSE was largely made up of nurses and ancillary staff. One of the first measures adopted by the Government, the creation of the Pay Review Body, had as a goal to split NHS staff along 'professional' lines, and therefore divide unions such as COHSE which represented both professional and support staff (Harrison and Pollitt, 1994, p. 61-66). After 1983, unions representing a professional grouping, and which were pledged to a policy of no industrial action, were included as part of the Review Body system. What this meant in practice was that pay matters would no longer be determined by negotiation with these groups. With a large aspect of the collective interest now gone, it was less likely that a common front action, as had occurred during the disruptions of 1982, would occur again.

Paradoxically, while the creation of the Pay Review Body divided NHS' staff, it also offered those unions which participated in them an independent means of improving their salary awards. This was particularly important considering the politicized manner in which public expenditure decisions were sometimes taken.

The other policy which impacted on the trade union movement was the move towards public tendering of NHS services. To a Government determined to reduce the staffing numbers of the NHS (Treasury, 1985, p. 163) such a policy also provided the opportunity to restrain costs and reduce the level of union membership in the NHS. Thus, between 1978 and 1987 over 51,000 jobs were lost in the ancillary and support grades of the NHS (Treasury, 1988, p. 250). For a union such as COHSE this had a major impact

on its overall membership figures. Nor were the unions successful in influencing policy. Although unions such as COHSE did appear before parliamentary committees concerned with the Health Service, they had little influence on the outcome of policy (personal interview GB 9).

In closing, one of the interesting differences which exists between the Canadian and British cases concerns the non-governmental actors which I have just discussed. As is clear from the above discussion the Thatcher government was not above attempting to shut out actors from the policy process. Under Mulroney, groups similarly without access to the Government tended to band together into larger coalitions and in this manner attempted to sway Government policy. A critical mass strategy which had some success. In the British case this did not occur. There was no attempt by the doctors' groups to band with community health or labour groups or any other similar permutations. Non-governmental actors remained isolated and continue to engage the Government individually, partly because of their divergent priorities. Nurses or support staff, for example, were critically concerned with economic issues affecting their salary and working conditions, while GPs were for the most part independent contractors in their relationship to the NHS. The view of resource allocation of one did not necessarily match with that of the others. This economic division would thus curtail their ability to coalesce vis-à-vis government policies. Another factor affecting the formation of coalitions concerns the credibility of the trade union sector. Thus, the isolation of trade unions from other interest groups is possibly explained by their being seen as narrowly focused, self-interested, organizations primarily interested in parochial economic issues to the detriment of wider health policy. The leading role of COHSE in the industrial unrest of the late 1970s undoubtedly contributing to this perception. This militant

tradition and the unions association with the Labour Party made the union sector very unlikely bedfellows for other groups. In Canada, I note in passing, that the two health policy coalitions split along similar lines, with one clearly union dominated and another provider dominated. However, the absence of similar organizations at a time of such flux in overall NHS policy is both interesting and surprising. Paradoxically, although the BMA acted very much as a trade union in its relationship with the Government - particularly around the time of the 1990 reforms - the medical profession appears to be able to shed its representative cloak rather easily and continues to be seen as a credible advocate for the NHS. I will return to this issue following my consideration of the Canadian case study.

5.7 Summary and conclusions

> I'd either leave it entirely alone, because it is too politically dangerous. Or I'd destabilize it, and see what happens (Independent, 9 February 1989).

It is with those words that a senior civil servant was reported to have responded when asked by an interested party how he would deal with the NHS. As the preceding discussion shows, the rationale behind the policies pursued by the Thatcher Tories resides somewhere between these two extremes. It is true that the fundamental principles of the NHS were maintained and protected by the Thatcher government - Mrs Thatcher herself took on the mantle of protector of the NHS in 1982. Even after the changes instituted in 1989 the NHS outwardly continued to function as it did before 1989 - in fact as it had since 1948. Internally, of course, the situation was much different as a new administrative regime began to take-over in the NHS.

Thus, the conclusion that the NHS was left alone seems appropriate. However, the proposition that change could occur through a policy of destabilization also appears

plausible. As I have shown, beginning in 1979 the Government forced upon the NHS severe cost containment measures. Although, as the Government frequently stated in its defence, the real terms cash funding of the NHS continued to grow, a cash crisis did hit the Health Service in 1987 and only then did the Government proceed with a review, a review which it had been privately considering since 1986. Thus, perhaps the NHS was destabilized sufficiently to allow the opening of a policy window through which emerged *Working for Patients*. This returns us to Döhler's (1991) description of the three periods in Mrs Thatcher's NHS policy, periods which were marked by an increased desire to 'do something.' Thus in the first phase the status quo is largely preserved. In the second, general management is introduced thereby giving the NHS its first real shock. In the third phase the final and most severe shock arises out of the IM reforms which the general consensus seems to indicate is the most revolutionary solution ever grafted to the NHS since 1948.

My argument throughout this chapter has been that the outward policy of the Thatcher government was primarily concerned with generating 'value for money.' This policy took on many forms, from management reform in 1982, through pay reviews and contracting out in the mid-1980s, to the development of an internal market where financial accountability, cost, and efficiency were the main factors in the new relationship between the various components of the NHS. This was not a policy unique to the health system, although it was a remedy applied later to NHS than to less politically sensitive areas of public policy such as housing or education.

These conclusions cannot be divorced from the general themes in the politics of the Thatcher government. The policies pursued in the health care system also exhibited the desire to move the state out of the business of providing services to the population,

especially where the private sector could, and largely does now, equally provide. This can be seen in the tax policies of the Government which aimed to encourage the take up of private health insurance policies. Issues of social justice, redistribution of wealth, and universality of access are not those which most concerned the Thatcher government. Rather, the desire to control state spending was primary. Where it was impossible to remove the state entirely from the area of service, such as in health or education, then this sector was to be administered, evaluated, and managed by a market philosophy. The Government was also keen to promote the private provision or supply of previously public services. The contracting out of services such as catering is an example of such a drive.

Coming, as it did, at the tail end of the Thatcher era it is perhaps evident that the IM should be considered as the edifice which concretizes a variety of policy objectives. Cost control, or value for money, improvements have to be seen as central to why the Government acted as it did. Another strand, however, is to see the post-1990 NHS as embodying the ideology of consumer empowerment. With the IM the Government sought to shift power away from providers and into the hands of consumers. While the rhetoric of consumer empowerment was used by the Government in effect little changed. The power relations among the agents working on a patient's behalf may have been altered - most likely as a result of the shift in resource allocation and less because of the discipline of the market. Granted, consumers now have greater ease to select their GPs, but these same consumers do not choose either their treatments or - in the public NHS at least - where, how and when this treatment will be offered. Having said this, the pre-IM system was no better at dealing with consumer/patient wants, but the consumer satisfaction failings of the NHS had been known for years (for example, these were noted in the

Merrison Report). The IM is therefore a good example of the expectation of choice applied to a service and institution where choice is neither practical nor possible in most cases.

Although it is clear that the Internal Market reforms mesh with the idiom of Thatcherism and the New Right what is critical for this study is how radical this policy stands as compared to those policies instituted by the Mulroney government. These broad changes included shifting the centre of accountability - this time to both the local level and within the walls of independent clinics and hospitals thereby altering significantly intra-NHS relationships; a change in the method of resource allocation - hospitals and certain types of general practice could now operate in a more 'business-like' manner making resource allocation decisions which had previously been the well guarded preserve of officials a the DHA level; and making the Audit Commission responsible for the quality of service and expenditure in the NHS thereby shifting power to an organization removed from the world of health. The intersection of these reforms altered the composition of health sector policy communities as fundholding GPs - to name just them - now operated along different prerogatives and with differing goals from their non-fundholding counterparts. A similar change in identity could be said to have occurred among administrators. In fact, with the advent of the Internal Market this latter group become an increasingly powerful force in NHS decision making and a strong counterweight to the traditional power of the medical profession.

In relation to the themes of this research the following can be highlighted. Despite having to operate within political constraints and limited by the institutionalized nature of the NHS the Thatcher Government appeared willing - as it did with the introduction of General Management or the Internal Market - to use the policy

instruments at its disposal to affect big change where it could. Several of these changes, or the rationales behind them, can be ascribed to the New Right themes discussed above such as a desire to introduce market devices or the control public expenditure. However, despite the Government's ideological propensities the NHS was preserved largely due to the political consensus which surrounds it, thereby affirming its irreversibility. A consensus which forced the Government to pursue policies not unlike those of its Post-War forebears. These themes will now be considered in relation to what many commentators have described as a much less radical attempt to re-shape the Canadian health system along New Right precepts.

Part III, Chapter Six:

Foundations to Mulroney Health Policy

6.0 Introductory Comments

In Part II I examined the record of the Thatcher government's NHS policy. It was argued that under Thatcher this sector underwent a number of major policy changes (departures) ranging from the structural (the 1982 reorganization) to the administrative/cultural (the Internal Market). By contrast the record of the Mulroney government is rather sparse in terms of both the number and the scope of the policies initiated. This, I will argue, is largely the result of institutional factors. However, as will also be shown, although the Mulroney record in health is more narrowly focused on fiscal changes, this is an area where it proved far more active than its British counterpart.

6.1 The Liberal imprint

The Mulroney government was elected in September 1984 with the largest majority in the history of the Canadian Parliament and was re-elected in November 1988 with a reduced but still considerable majority in the House of Commons.[1]

The Mulroney Tories entered office after virtually uninterrupted Liberal Party government in the Post-War period with the exception of two brief interludes (1957 - 1963 and a nine month minority government in 1979-1980)(Jackson et al., 1986, p. 261). Thus, with the exception of HIDS, initiated by a Liberal government but legislated by a Conservative one, the shape and scope of Canada's social system is largely a legacy of the

[1] The results of the 4 September 1984 election were: Progressive Conservatives 211, Liberals 40, New Democratic Party 30 and 1 Independent (Jackson et al. 1986, p. 522; see also Erickson, 1995).

Liberal Party.[2] The Mulroney government was therefore constrained by inherited policies and welfare state institutions which the Progressive Conservative Party had limited input in developing. Moreover, like their British counterparts, the Mulroney Tories were having to deal with policies and programmes which had institutionalized themselves in Canadian political culture. However, although these inherited policies presented the Government with constraints, they also created policy tools (such as the EPF) which the Mulroney government would utilize with frequency.

Before dealing with the details of the Mulroney government's health policy it is useful to consider the political dynamic underlying the policies of the Mulroney Tories. With the election of the Conservatives in 1984 Canada became the latest adherent to the neoconservative club. But, it is also true that many neoconservative policies had been implemented before this date.

The 1945 to 1980 period in Canada was marked by unprecedented and almost uninterrupted economic growth which made possible the expansion of social programmes, policies which touched Canadians across the country and every social strata. The Oil Shock induced recession of 1975 however reduced and staggered this growth (Bothwell et al., 1993, p. 477). Much as occurred in Britain under Labour, the Oil shock of 1973 and its reverberations forced the Liberal Government of Pierre Trudeau into instituting policies which would later become part of the panoply of the New Right.

In late 1975 the Canadian economy was in the grip of hyper-inflation and stagnant economic growth, a situation which was attributed by the Department of Finance to

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[2] While this is factually correct in terms of the government in power in Ottawa at the time that federal legislation was enacted, it is important to note the seminal role played by the CCF/NDP in establishing programmes at the provincial level (Saskatchewan) and championing these at the federal level (Swartz, 1993; Weller, 1983). Maioni (1994) points to the existence of the CCF/NDP as one of the factors that forced the governing Liberal Party to act in this area following WWII.

excessive levels of government spending. Between the 1973-74 and 1975-76 fiscal years the annual growth in federal spending exceeded 20 per cent. To correct this situation the ministers of finance and the Treasury Board, with the support of Prime Minister Trudeau, mapped out a spending restraint programme that would affect all areas of federal activity (Savoie, 1990, p. 149). The cuts identified by Finance and Treasury Board were announced in January 1976 and totalled $963 million, $299.7 million coming from various health and welfare programmes. But this was just the initial phase of cost cutting as another round of cuts was instituted in the autumn of 1975, although these were targeted primarily at administrative costs (salaries, travel costs, stationary) rather than programmes (Savoie, 1990, pp. 149-150).

Another change aimed at reducing it fiscal exposure instituted by the Trudeau government was the creation of the EPF which I discussed in Chapter Two. The move away from a transfer tied to provincial expenditure to one tied to GNP growth would itself result in a $1 billion saving for the Government in the 1977-1978 fiscal year (Savoie, 1990, p. 150). However, despite managing to keep expenditure growth below the growth rate of the GNP the state of the economy and the rate of inflation (over 10 per cent in 1977-1978) showed no sign of improvement (Savoie, 1990, p. 151; Bothwell et al., 1993, pp. 323-325).

The Bonn Economic Summit of 1978 provided the catalyst for the second major attack on inflation through cuts in federal spending. In a July 1978 television address Trudeau called for a "major re-ordering of Government priorities" and an immediate $2 billion cut to federal spending. The decisions as to the details of this cut were to be left to individual departments (Savoie, 1990, p. 152). Leading up to the Government's "conservative" budget of November 1978 the Treasury Board announced immediate cuts

of $1.5 billion in August 1978 with an additional $1 billion added the following month. Although these savings appear substantial they were primarily achieved through reductions in already committed spending and minor programme cuts. In addition the budgets of federal departments were "shaved" by varying percentages (Savoie, 1990, pp. 153-154).

What is interesting to note here is that with the exception of the creation of the EPF and the $299.7 million cut in health and welfare programmes the Liberal government's commitment to social programming was largely spared despite the recourse to neoliberal fiscal policies. Moreover, as the election of 1979 approached the Trudeau government lost some of its resolve and $300 million in new money was announced for job creation and industrial development (Savoie, 1990, p. 156). However, the Trudeau government had not managed to reverse the economic malaise and in May 1979 Canadians elected a minority Conservative government led by Joe Clark whose policies included plans to reduce the federal deficit and privatize state corporations (Bothwell et al., 1993, p. 331). Clark himself was of the Red Tory tradition but he attempted to bring together the two strands of conservatism in the party - the business-liberal strand and the traditional Tory strand and its belief in necessary *étatisme* (Campbell and Christian, 1996, pp. 45-46). However, nine moths into its mandate the Government was defeated on a vote of non-confidence leading to the re-election of the Trudeau Liberals. One of the main reasons for this defeat can be attributed to the Clark government's prescription of tax increases, privatizations and deficit reductions (Jackson and Jackson, 1994, p. 585).

Returned to office the "Trudeau government was in no mood to pursue spending cuts or stick to its objective of limiting growth in (federal) spending to increases in the GNP" (Savoie, 1990, p. 156). With the inflation rate still high the Government

introduced measures such as its "6 and 5" anti-inflation programme.[3] However, between 1980 and 1984 the Trudeau government initiated over $6 billion in new spending the bulk of which was spent in its last year in office. Although spending cuts were still occurring, for example $454 million was cut from low priority programmes, the moneys saved "were mostly ploughed back ... to permit new spending" (Savoie, 1990, pp. 156-157). The Trudeau government's flirtation with neoconservative economic policy was over. However, by these policies, especially the post-Bonn cuts, the Government had softened official Ottawa to New Right fiscal policies.

What is useful to note from the above is that Canada was not immune from the rightward drift in policy which the economic crisis had brought about. Moreover, Canadians themselves were not averse to the solutions proposed by the Right to deal with the circumstances of the crisis as the vote for Clark attests. In this sense, the main contribution of Mulroney to Canadian Conservatism was not in redefining the party's ideology or the role of the state in the lives of individuals (as Mrs Thatcher could be said to have done) but rather in building an electoral coalition - in terms of both policies and individuals - which could break the Liberal Party's stranglehold on Ottawa. To build such a coalition required political pragmatism - a pragmatism evident in Mulroney's health policy.

6.2 Policy and Politics under the Mulroney Government

One of the main features of the Progressive Conservative Party of Canada is that it is essentially geared to winning elections rather than pursuing a particular ideological

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[3] Under "6 and 5" increases to the wages of federal employees, for example, were limited to 6 per cent in 1981 and 5 per cent in 1981. The Government further encouraged other sectors of the economy to limit their price and salary increases to 6 and 5 per cent.

agenda. The party can trace its origins in a conservatism rooted not in liberal-individualism, as championed by Reagan and Thatcher, but in "true conservatism" built upon "collectivism, privilege and the inadvisability of revolutionary change" and to a degree nationalism (Manga and Weller, 1991, p. 213). Although the rhetoric of the party under Mulroney echoed that of US and British neoconservatism, it would not match their programmes.

In a book published shortly after becoming Tory leader entitled *Where I Stand*, Brian Mulroney (1983) set out the themes and priorities of the Conservative Party under his direction. Central to his politics was the need to control public expenditure, with a particular emphasis on ending inefficiency and maladministration (Mulroney, 1983, pp. 43-44). For Mulroney the only economic role for government should be to foster private enterprise and improve trade. Accordingly, Mulroney believed that it was the private sector, not government, that was the engine of economic growth (Mulroney, 1983, pp. 90-91). Mulroney's book, however, does not present detailed views on social policy - rather readers are treated to short passages on the virtues of hard work and self-help (Mulroney, 1983, p. 88). All of these themes would find a place in the policies of his government.

During the 1984 election campaign Brian Mulroney had fought off accusations from the Liberals and New Democratic Party (NDP) that his party was planning significant changes to Canada's social welfare programmes by declaring that social programmes were a "sacred trust." Although committed to fiscal restraint, if elected, the Conservative's vowed to protect social spending (Bercuson et al., 1986, p. 94). First among the Government's priorities would be reversing the high inflation and unemployment which had crippled Canada's economic performance. To get Canada's

economy on a proper footing "businessmen, economists and Conservative politicians claimed that Canada had to get its massive budgetary deficit under control before the economy could recover" (Bercuson et al, 1986, p.94). By the 1983-84 fiscal year the federal government's budgetary deficit was $32 billion (up from $14.5 billion at the start of the 1981-82 economic recession and up from $1 billion at the start of the 1970s). This situation had a dramatic effect on the federal government's rate of public borrowing and by the 1983-84 fiscal year nearly 25 per cent of the federal government's spending went to paying interest on the national debt (Bercuson et al., 1986, p. 95). As I noted above Canadian governments were not immune from the shift to neoliberalism in Western economic policy, where it was believed that there existed a need to balance government revenues and expenditures (Bercuson et al., 1986; Savoie, 1990; Bégin, 1988; personal interview CDN 13). Economic recovery, the prevailing economic theory argued, required governments to reduce their deficits. The Mulroney Tories were believers in these neoliberal economic theories and they made deficit reduction - as well as job creation - the main part of their agenda (Bercuson et al., 1986, p. 95). The problem for the Tories, and the source of the Liberals' and NDP's election trail accusations, was that much of the federal government's spending was taken up by money spent on statutory programmes such as Old Age Pensions, Family Allowances, and Medicare. Thus, Mulroney's claim that social programmes were a 'sacred trust' "brought the concepts of fiscal and social responsibility into constant conflict" (Bercuson et al., 1986, p. 95).

Unlike the Thatcher government, whose main concern was the control of inflation, the Mulroney government's main policy objective was a reduction in the federal budgetary deficit and the national debt. A tight control on public expenditure, however, proved a common tool for both governments. In the Government's first *Speech from the*

Throne the issues of debt and deficit reduction insinuate themselves into virtually all the topics raised in the Speech. Thus, fostering economic renewal is seen as conditional on fiscal renewal and both are preconditions to achieving goals as diverse as a constitutional accord or greater social justice (Debates, 5 November 1984, pp. 4-8). The policy of debt and deficit reduction was addressed by the Government in a number of early initiatives. The first was the formation of the *Ministerial Task Force on Program Review*, followed a few weeks later by Minister of Finance Michael Wilson's *Economic and Fiscal Statement* and accompanying policy document entitled *A New Direction for Canada.* This document was described by the Minister of Finance as more than a statement of the Government's economic programme, but as a "statement of national purpose" (Finance Canada, 1984, p. 3). As such, *A New Direction for Canada* sets the tone for the Government initiatives and policies that followed.

Read with hindsight both *A New Direction for Canada* and Wilson's Statement can be seen as the policy road map for the Government's actions between 1984 and 1993. Both set deficit reduction as the main goal of the Government and made the continued existence of Canada's social programmes subservient to this goal. On this score Wilson stated boldly that,

> (...) a review of existing social programs is necessary to ensure that the government's (sic) social policies are sensitive to the continually changing needs of Canadian society. The government (sic) agrees that a frank and open discussion is timely, and that there is considerable scope for *improving and redesigning social programs based on the twin test of social and fiscal responsibility* (Finance Canada, 1984, p. 71. Emphasis added).

Besides its social policy implications Wilson's economic statement presented the case of Canada's economy in classic neoliberal terms and offered classic neoliberal solutions to these problems. That is, a recipe for economic growth not unlike that

followed by Thatcher in the UK or Ronald Reagan in the US (Manga and Weller, 1991, pp. 210-211). In a larger sense, everything was on the table as far as Wilson and his officials were concerned. In a move meant to reassure Canadians about the future of social programmes Wilson pledged that the Government would not "violate the sacred trust of assisting those individual Canadians who need help" (Michael Wilson, 1984, p. 7). While meant to comfort those concerned about the future of Canadian social policy Wilson's comment introduced a conditional aspect to these programmes which had been absent from the pronouncements of previous governments. Previous to this Wilson's comments the hallmark of which had been the universal nature of its programmes. Wilson returned to this theme by stating,

> we must ensure that growth will be for the benefit of all Canadians and that the costs of change will not fall on those least able to bear them. To provide this assurance, we must make certain that those *who really require* social assistance receive it. We must also ensure that our social support systems *encourage self-reliance* rather than create a dependency on government (Wilson, 1984, p. 8. Emphasis added).

Although the Mulroney Tories were unsuccessful in matching their budget predictions with actual budgetary outcomes, it is none the less true that they effected quite a change in Canada's fiscal position. As Table 6.1 highlights, the federal deficit expressed as a percentage of the GDP/GNP dropped from a high of 6.8 per cent when the Mulroney government took office to a low of 2.2 per cent in 1992 - one year before being voted out. How this budget deficit policy affected health care is one of the themes explored below.

TABLE 6.1
Federal Government Budget Deficits 1984-1992[4] as a Per Cent of GDP/GNP (compared with G-7 average)

Year	1984	1989	1990	1991	1992
Canada	6.8	3.5	3.4	3.6	2.2
G-7	4.3	2.2	2.7	2.8	2.3

(Source: Finance Canada, 1991).

Thus it was that over the period in question these measures would be part of the mix of policies aimed at deficit reduction that eventually involved cuts to transfers for health. As can be seen from this rapid overview, it is obvious that the Government was keen to follow upon its original plan of action, but may have slowed down its efforts after the 1986 budget, due to negative public reactions[5] to tax increases, forcing it to rely on seeking cuts in the 'invisible' sectors, such as public administration and transfers to provinces.

A few short words about the other Mulroney government priorities. The constitutional[6] issue is one which was very much at the heart of the Mulroney government's priorities. Mulroney had personally staked his government to finding a constitutional accord acceptable to the Government and people of Québec. However, two attempts at a constitutional accord failed to be enshrined. According to some inside the Government Mulroney's desire to cobble together a constitutional settlement would become an obsession, particularly after the failure of the Meech Lake Accord (personal

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[4] Figures for 1992 are projections.

[5] The fact that the Government, and Minister Wilson in particular, held back from more severe reforms due to the limits of public acceptance was noted in personal interview CDN 1.

[6] See Russell (1993) for a complete overview of the Mulroney constitutional saga.

interview CDN 1; Russell, 1993). The Tories' desire to heal federal-provincial relations can be interpreted largely in terms of Brian Mulroney's interest in the constitutional question. The centrality of the constitutional question to Government policy is highlighted by its inclusion in *A New Direction for Canada* (Finance Canada, 1984, p. 82) and Wilson's 1984 Statement where, he stated, "[dialogue] will take the place of confrontation" in intergovernmental relations (Wilson, 1984, p. 1). Health minister Jake Epp's relationship with the provinces, and his enforcement of the *Canada Health Act*, would be sharply influenced by this doctrine (personal interview CDN 1).

While these statements may have heralded a new style on the part of the federal government in its relations with the provinces, there were higher political stakes at play. To achieve his goal of reaching a constitutional accord acceptable to Québec, thereby keeping with his promise to the nationalist elements he brought into his electoral coalition, Mulroney needed the remaining nine provinces on side. Moreover, other elements of the Tory agenda, such as liberalized trade and reducing the size of government, would be that much easier to achieve if they were done without the usual federal-provincial bickering. But appeasement, if that is in fact what occurred under Mulroney, would also remove the federal government from key sectors of Canada's social and economic life.

Other issues intruded over the Government's two terms in office. The first was the issue of freer trade. The negotiations and signing of the Canada-US Free Trade Agreement (FTA) in 1989 led to heated debate among proponents and opponents of freer trade. The FTA is linked to the New Right inspired policies of liberalizing the marketplace and facilitating the role of the private sector in creation of wealth and the country's economic growth and well-being. At first luke-warm to the idea of the FTA

this soon became the principle economic policy of the Government following deficit reduction (Doern and Tomlin, 1991, pp. 23 - 30).

More closely related to its deficit reduction targets was the Mulroney government's concern with reducing the size of government and streamlining its regulatory role. These policies mirrored those pursued in the UK with the accent placed upon privatization and improving the efficiency of the governmental apparatus. First to consider these goals was the *Ministerial Task Force on Program Review* (Nielsen, 1985) chaired by the Deputy Prime Minister, Erik Neilsen. Although differently structured the Nielsen Task Force was very similar to the Rayner Efficiency Unit (Simeon, 1993; Nielsen, 1989; Nielsen, 1985). In terms of this study the Task Force is important as it was the first Mulroney initiative to review social programmes such as Medicare, the *Canada Health Act* and the EPF (Nielsen, 1985, pp. 11-12).

6.2.1 Summary and observations

The preceding discussion focused on the priorities and policies which the Mulroney government brought with it into office. My intention above was to begin to show a link between the macro-policies of the Mulroney government and the micro-policy field of health. Although the areas of intervention discussed above are somewhat at a distance from that of health, a number of themes link both discussions.

The first theme needing consideration is that of the presence of a distinctive New Right agenda. Banting (1991and 1992) notes the relative lack of a radical version of a New Right ideology in the policies of the Mulroney administration - a situation which he compares with Britain. But Canada was not immune from the changes in the world political economy in the latter half of the 1970s and a perceptible shift occurred in its

public policies around this period. Thus, as Bégin (1988) has noted, a more "conservative" outlook on public policy and the role of government, particularly with regards to public expenditure, emerges during the Trudeau mandate. However, similarly to Britain where the shift to control of public spending began under a Labour government, the successor to the Trudeau Liberals in 1984 took this goal and elevated it to the level of policy mantra. Thus, from Mulroney's 1983 'stand' on expenditure control through to the economic papers of Michael Wilson at Finance it is clear that the Tory government was much more determined than its predecessor to do something about expenditure. But is this truly a New Right cause? It is true that all governments of whatever political stripe seek to economize as best they can. This was noted earlier in the context of British NHS policy (personal interview GB 5) and it is also true in the Canadian case. However, expenditure restraint becomes a New Right theme when this becomes a policy goal in and of itself. The reduction of the deficit and national debt became under Mulroney the primary policy goals of the Government. The desire to economize was not linked to a great extent to generating savings for other policy initiatives. Rather, it was believed by the Government that expenditure control was the key to economic renewal and growth in line with neoliberal economic theories. Related to this goal of expenditure restraint were attempts at generating efficiencies in public administration. Once again, as evidenced in the Nielsen Task Force, the perception of government being an obstacle to growth and development, as well as being a drain on national wealth, permeates the mandate of the inquiry team. Finally, and as I will discuss more closely below, the linkage made between Canadian social policy and the economy's ability to generate sufficient growth outlines the New Right agenda in a sector of activity in which only government was a player. The primacy given to fostering private sector

development, as also advanced in the Government's fostering of international and internal trade, all centre on the same ideological proclivity.

Institutional issues which will have relevance to my case study can also be discerned above. The agenda of the Mulroney government was one primarily focused on sectors where the federal government could act exclusively. Thus there is little in *A New Direction for Canada*, beyond a statement that the burden of deficit reduction will need to be shared, that lets one believe that the federal government was seeking a collaborative approach to Canada's public policies. As I shall show below the decision to control the federal deficit through successive cuts to the EPF was done without consultation with the provinces, although it is this level of government that would have to bear the costs and consequences of these cuts. In terms of spending and spending control, the BNA and the agreements between levels of government left Ottawa with plenty of latitude in reorienting its expenditure plans.

While the Government's New Right inclinations and the nature of the institutional field in which it governed are important, it is also important to remember that the Progressive Conservative Party - in and out of government - was primarily motivated by the desire to win elections (Manga and Weller, 1991). Its priorities were conditioned by this overarching goal. The desire to find a constitutional option acceptable to Québec was directly related to the party's need to maintain its electoral standing in that province. Mulroney himself identified a Conservative breakthrough in that province as one of his main goals (Mulroney, 1983, p. 91). Additionally, free trade and expenditure cuts were also appeals to the party's main constituency - Canada's business community.[7]

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[7] The impact which this segment of society has had on Canadian public policy development, particularly under the Mulroney government are chronicled by business journalist Linda McQuaig (1991 and 1995).

While there are many similarities in the policies and rhetoric of the Canadian and British Conservatives (although a wide difference in policy outcome) they differed in the degree to which they appealed to nationalism as an integral part of their politics. Thus, while the British Conservatives articulated a clear vision of British pride and accomplishment (particularly after the Falklands War) in Canada Mulroney's nationalist message was mixed. Mulroney broke with the nationalism of traditional Canadian Conservatism and espoused foreign and trade policies closely allied to those of the US. Mulroney's business-liberalism therefore clashed with the prevailing mood of economic nationalism which pervaded Canadian political culture. This clash has been suggested as one of the main contributing factors to the Conservative collapse in the 1993 general election (Campbell and Christian, 1996, p. 185). However, if economic nationalism was the preserve of the Canadian Centre and Left, Mulroney none the less played the nationalist card in his pursuit of a constitutional agreement and in certain aspects of the Government's cultural policy (Campbell and Christian, 1996, p. 179). However, with the FTA Mulroney and his party had inextricably tied Canada's future to that of the US and, as such, his nationalist appeals were primarily Band Aids to be applied against the constitutional sore rather than a dynamic affirmation of Canadianess. As such, the nationalism of Mulroney was one steeped in compromise in pursuit of constitutional renewal while that of Thatcher was a nationalism that was dogmatic and uncompromising, a nationalism which blamed Labour and the trade unions for having let the 'Great' slip from Great Britain.

In short, the outline of the Government's policies with regards to health can be discerned early in the life of the Mulroney government.

6.3 Social policy under Mulroney

It was previously noted that Mrs Thatcher's social policies present a paradox. On the one hand the NHS was largely protected from the fiscal and privatization drives which marked overall public policy, while on the other the social housing sector was vastly reduced in favour of residual assistance and the private market. This paradox was explained by the relative place each programme occupied within the wider British welfare state. A similar paradox existed in Canada under Mulroney where attempts at rollback were successful in some areas, but thwarted in others. Moreover, institutions also defined this outcome. Although this is a study of federal policies the particularities of the federal structure of Canada's government and its attendant mode of fiscal federalism provides for significant involvement by provincial governments in policy innovation and programme administration.

As was discussed above the development of Canada's health system is linked to the expansion of the welfare state beginning in 1927 with the introduction of Old Age Pensions. By 1968 and the election of the Trudeau Liberals the welfare state was engrained into the Canadian political consciousness and its expansion had reached its acme. When the Tories were elected in September 1984, social spending accounted for approximately 40 per cent of the federal budget (Bercuson et al., 1986, p. 96). Spending on social programmes at the provincial level was commensurate. But could Canada as a nation continue to afford this level of social spending? This question was asked with increasing frequency as the 1980s recession took its toll.

The Conservative's had always accepted the political necessity of the Canadian welfare state, although as a party and government they had little to do with its actual creation and expansion. The Tories had supported the establishment of family allowances

in the 1940s and Medicare in the 1960s and Prime Minister Diefenbaker was instrumental in the establishment of HIDS in 1957. In 1984, the then opposition Mulroney Tories had sided with the governing Liberals and opposition NDP to achieve unanimous support for the *Canada Health Act* (Bercuson et al., 1986, p. 97; Taylor, 1987, pp. 34-35). Thus it can be said that between 1927 and 1984 the federal Liberal Party and the federal Tories - in and out of power - shared common views on the Canadian welfare state. Neither was for wholesale expansion but neither did they argue for its dismantling. However, with social spending nearing 40 per cent of the federal government's spending a major review of social programmes would be in the offing irrespective of the party in office in Ottawa (Bercuson et al., 1986, p. 98). A new government - more so one committed to the free market - may have facilitated this process of re-examination. In the next few pages I will discuss some of the Tories' most important social policy initiatives which, on the whole, say more about the Government's economic rather than social priorities.

To situate the Government's social policies it is important to return to *A New Direction for Canada.* The paper restated the Government's commitment to the 'safety net,' but also called for a re-examination of social policy (Finance Canada, 1984, p. 71). In particular, the Government posited the need to rethink the commitment to universal social programmes in the areas of child and elderly benefits, reorienting the unemployment insurance programme to remove from it "obstacles to labour market adjustment and to economic growth and investment" (Finance Canada, 1984, p. 77), and redirecting the federal government's public housing programmes towards those who "are truly in need of such assistance" (Finance Canada, 1984, p. 80). Also subject to re-examination were the federal transfers to the provinces under the Established Programs Financing (EPF), the Canada Assistance Plan (CAP), and equalization. Stating that

transfers to the provinces consumed approximately $18 billion or about 20 per cent of the federal budget in 1984-85, the policy paper asksed, "if the federal government is to contain its expenditures in general, it is appropriate to ask whether transfers to the provinces should be insulated from policies of restraint?" (Finance Canada, 1984, p. 81). Protecting these transfers meaning that restraint would need to fall more heavily on other programmes, most entirely federal in nature (Finance Canada, 1984, p.81).

On the EPF *A New Direction for Canada* acknowledged that much discussion had already taken place with regards to how these programmes were funded, but that much remained to be discussed. Meetings between the federal and provincial finance ministers were to be the starting point for discussions leading to "the fiscal arrangements for 1987-1992" (Finance Canada, 1984, p. 81). Recognizing the role of the provincial governments in matters of health and post-secondary education, the federal government stated that containing costs and reducing deficits was a concern for both levels of government and health and post-secondary education were "undoubtedly" areas where both could determine priorities and "work more effectively and efficiently to contain pressures on scarce financial resources" (Finance Canada, 1984, p. 81). The answer was not to be found in additional funding, rather existing resources had to be used more effectively: "It is time for all interested parties to look for new approaches within the limits of budgetary realities" (Finance Canada, 1984, p. 81). We would see this theme repeated at several occasions in the ensuing years.

The link made by the Government between social policy and fiscal policy is evident in a 1985 consultation paper on child and elderly benefits, two programmes which would eventually face the Department of Finance's deficit cutting policy. The key element of the Government's approach announced in the consultation paper was that,

> no further expenditures additional to those already in the budget will be undertaken in 1985-86 on programs (sic) to provide social benefit, except where these can be funded by reallocating resources already committed for programs (sic) in the social field (cited in Prince, 1985, p. 153).

As its main social policy tool the Mulroney government utilized the budgetary process. A shift from universal programmes to selective ones increased the reliance on the tax system for delivering social security benefits. This resulted in a transfer of the burden for social security to individuals earning between the poverty line and $30,000[8] (Rice, 1987, pp. 220-221). However, the Government's ability to proceed with major alterations of its social expenditures was limited in two ways. Firstly, many of the programmes were statutory in nature, thereby requiring Acts of Parliament to alter these. The second factor was the existence of a consensus among Canadians that a 'contract' existed between them and the Government - changing the legislation could only be done at great political risk[9] (Rice, 1987, p. 221). This recalls a similar limitation to change in Britain's Social Security system. Which is not to say that the Government was unwilling to take these political risk.

None of the Mulroney government's social policy initiatives would have been possible without some congruence and acceptance on the part of the Canadian public. On this score the Mulroney Tories proved themselves very adept at convincing Canadians that their message of fiscal restraint was the right one for the times (McQuaig[10], 1993, pp. 14-15, 18, 25).

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[8] One of the main goals of the Conservative government was to shift the reliance of the social system away from universality and towards a regime of selective eligibility (personal interview CDN 1). This movement has been profound with OAS and Family Allowance schemes (Rice, 1987, p. 222). Moreover, this gradual move towards the selectivity was evident in Government and ministerial pronouncements regarding the need to reorient programmes towards those who are in "greatest need" (Finance Canada, 1984, p. 71).

[9] Public reticence to large cuts was also noted in personal interview CDN 1 where it was stated that "[translation] Wilson would have gone further, but the degree of acceptance of Canadians wasn't there."

[10] McQuaig (1993) makes a strong defence of the Canadian welfare state, indicting the Mulroney regime with trying to dismantle Canada's very successful social welfare net. McQuaig (1991) also strongly

Banting (1991), summarizes Conservative social policy and its effects:

> [social policy] remains a core element of Canadian society ... [although] this overall image of continuity obscures important changes .... Closer examination highlights areas of serious erosion, the restructuring of others in a form more compatible with the economic forces of the decade, and a slow drift toward a less progressive system (Banting, 1991, p. 44).

However, in contrast to the Thatcher government, the Mulroney government was not gearing up to change society. In this it was constrained by the welfare state's role as a "critical instrument" of national integration and the fact that "the public support for the welfare state remains strong" (Banting, 1992, p. 154). Its legitimacy is not an issue for Canadians. On the contrary, social programmes, such as Medicare, could be said to be deeply engrained in Canadian culture (Banting, 1992, p. 154).[11] Although equally engrained in British political culture, in Canada social policy - and health in particular - had been one of the main tools of nation building unifying a bicultural country spread across a continent and perceived by many to be under threat of assimilation by the US. As Bothwell et al. (1993, p. 477) note, the economic prosperity of the Post-War permitted an increasing social presence by the state leading to the creation of programmes for all Canadians. This welfare nationalism came to substitute for economic nationalism and ensured that "national minimum standards should be available to all Canadians" (Campbell and Christian, 1996, p. 172). Couple with federal equalization payments, Canadian identity became very much linked with a concept of equality of governmental services and programmes overlaid upon regional and cultural distinctiveness. To be Canadian, therefore, was to have access to Medicare rather than an identification to a

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criticizes the disproportionate influence which the business community had in initiating policy during the Mulroney decade.

[11] A public opinion poll conducted by the weekly news magazines Maclean's found that most Canadians listed Medicare above hockey as a defining characteristic of being Canadian (Maclean's, 1 July 1994).

sense of place or history.[12] Thus, in power the Mulroney Tories were more intent on securing their electoral gains than following the lead of fellow conservatives in Westminster and the White House. Equated, as it was with national identity, "a radical assault on the welfare state was a dubious place to start [building a political base]" (Banting, 1992, p. 156). In short, because social programmes were embedded within the national identity and, moreover, were critical instruments of national integration the Mulroney government was forced to act moderately with respect to this area of public policy.

The Mulroney Tories were no revolutionaries and their approach to social policy was a very careful one. Burnt in its first term by an attempt to deindex Old Age Pensions the Mulroney government soon adopted what Banting terms "the politics of stealth" (Banting, 1992, pp. 156). This strategy implied a concentration on low-visibility policy instruments in dealing with reductions in welfare coverage. Entering its second term, and under the veil of Canada's budget deficit crisis, several high visibility programmes saw their funding either frozen or chopped and new social policy commitments, such as child care, were erased while still on the drawing boards (Banting, 1992, pp. 156-57; McQuaig, 1993, pp. 120-137; see also Teghtsoonian, 1992). Notwithstanding these efforts, Canada's welfare state remained largely whole, albeit short a few limbs. Spared a neoconservative revolution, Canada did nevertheless experience neoconservative drift (Banting, 1992, p. 157). However, as will be shown below, although less inclined towards Thatcher style reforms, the Mulroney Tories were quite effective at constraining the growth of social spending, this was particularly the case in the area of health.

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[12] For example, opponents of the FTA most frequently cast their opposition to the Accord as necessary opposition and resistance to US influence and political culture. Thus, the need to defend Canadian social policies from negative harmonization with the US (Campbell and Christian, 1996, pp. 100, 183-184; see also Barlow and Campbell, 1991).

6.3.1 Deindexing Old Age Pensions

One of the main elements of the Conservative 1984 election platform was a promise to improve pensions for elderly Canadians including the removal of the cap on annual increases of the Old Age Security (OAS), a cap which the Trudeau Liberals had applied as part of their anti-inflation strategy. Soon after entering office the Tories made good on this promise and the full indexing of OAS to the consumer price index was returned (Rice, 1987, p.219). This promise and its delivery therefore make the May 1985 decision of the Mulroney government to restrain the growth in OAS payments that much more paradoxical. The saga of OAS deindexing informs this study in two ways. Firstly, as in the case of housing in Britain, it shows the Government establishing a criteria for what was and was not a key element of the welfare state needing to be preserved. Secondly, the very public manner in which the Mulroney government had to reverse itself on this policy highlights the constraint on radical policy change found in the weight of public opinion.

Savoie (1990) chronicles the process leading from the November 1984 cuts to federal spending through to the May 1985 budget. Beginning shortly after the election Michael Wilson set about chopping millions in federal spending through the winding down or sale of crown corporations, the cancelling of ambassadorial posts and pruning the line items in agency budgets. But, "[the government had] little time to congratulate themselves on the November cuts before they initiated a new round" (Savoie, 1990, p. 165a). Laying the groundwork for his first full budget Wilson would "up the ante" and set the Government on a course to net expenditure cuts of $15 billion by 1990-91. However, Wilson and his colleagues also realized that while the first round of cuts had been relatively easy and painless, the next round would affect programmes that came in touch

with Canadians directly. Thus, it was decided that an across the board freeze or cut was not the way to proceed, rather the Government would be selective in "eliminat[ing] or substantially reduc[ing] those that were at variance with the philosophy and approach of the new government" (Savoie, 1990, pp. 165, 166). Universal social programmes and social programmes indexed to inflation came within the reach of those in government examining where these new cuts could be achieved. However, the Government was hemmed by Mulroney's campaign promise that universality was a "sacred trust." This left it only one option - the deindexing of inflation protected programmes such as the OAS.

The rationale behind this decision to deindex programmes such as OAS was simple: "if the government was serious about cutting back spending ... [then] everyone should bite the bullet ... individuals as well" (Savoie, 1990, p. 167). Such a policy ran counter to the Government's earlier commitments and the gist of consultation papers that had been released in January 1985. No matter, Wilson's arguments prevailed and in his first full budget of 23 May 1985 he announced that OAS and Family Allowance payments would only be indexed to changes in the consumer price index in excess of three per cent. The savings generated by this measure would amount to $2 billion by 1990-91 (Savoie, 1990, p. 167).

Deindexing OAS, appearing in the budget speech only a few paragraphs after a new pension initiative, was justified by Minister Wilson as "a way to protect [Canadians] against rising deficits and the soaring national debt" (Debates, 23 May 1985, p. 5012). What this meant to low income elderly Canadians was that when inflation rose to or above three percent a year, their OAS cheques were being eroded by a similar percentage (McQuaig, 1993, p. 114).

It took exactly one month for the Government to reverse its decision and fully return the OAS' inflation protection. A political storm erupted four days after the budget speech after Official Opposition critics and social policy analysts and interests had had time to dissect the figures released by the Department of Finance. The major revelation contained in these was the fact that the Government's policy would mean a real terms reduction in OAS of $100 per year. "Since half the recipients of the [OAS] were poor ... the sum was significant" (Bercuson et al., 1986, p. 115). Soon opposition to OAS deindexing would count a wide variety of interests from opposition MPs to groups representing seniors, provincial governments and business representatives (Rice, 1987, p. 219). Further complicating the Government's defence of its policy were other budget related initiatives such as the full indexing to inflation of interest on government bonds and a $500 000 capital gains exemption (Bercuson et al., 1986, p. 116). To the public the Government seemed to be taking from the poor to give to the rich.

For two weeks the Government held firm but soon "the backpedalling began" (Bercuson et al., 1986, p. 117). As public protests gathered momentum across the country - one poll showed that 85 per cent of Canadians disapproved of the Government's decision to deindex OAS - Wilson and Mulroney began making contingency plans (Rice, 1987, p. 219). The final blow to the proposal came when the Business Council on National Issues (BCNI) and the Canadian Organization of Small Business, two key backers of the Government's hard-line on deficit and debt reduction, stated that OAS should remain fully indexed. On 27 June 1985 Wilson stood in the House of Commons and announced the Government's decision to reinstate inflation OAS' protection (Rice, 1987, p. 219; Bercuson et al., 1986, p. 118). Rice notes,

> The bungling of the de-indexation (sic) issue was a major failure of Tory social policy reform. Wilson learned an important lesson from his first major foray into

> social policy: changing the social security system must be a process of evolution — (sic) not revolution. Canadians have strong views about their rights to income security and the government must go slowly and balance changes within the system (Rice, 1987, pp. 219-220).

However, although the strength of popular opposition convinced the Government to back down on the deindexing of the OAS, another one of Canada's oldest social programmes, the four decade old Family Allowance, was deindexed with only minimal public attention or opposition. The Government's objective in modifying child benefits was to move away from a universal entitlement model to a selective one. To do so the 1985 budget deindexed the Family Allowance payment (approximately $34 monthly per child under 18) while at the same time lowering from $26,330 to $23,500 the income threshold at which the Child Tax Credit was phased out. This ceiling was also deindexed. Combined these two measures ensured that each year a fewer number of Canadians - particularly the low income - would be receiving Government financial assistance. These measures were followed in 1986 with further adjustments to the Child Tax Credit geared towards Canadians with a combined family income below $15,000. In the February 1992 budget the Family Allowance - whose real terms value had been steadily declining due to deindexing - was cancelled and replaced with adjustments to the Child Tax Credit which further reduced Ottawa's financial commitment to low income families (Rice, 1987, pp. 217-222; McQuaig, 1993, p. 25).

These changes to child and family entitlements were possible due to the very different place these programmes occupied in the Canadian welfare state. As McQuaig (1993, pp. 25-27) highlights, the fact that the Family Allowance represented a small percentage of family incomes as opposed to the sizeable impact which the OAS had on the income of the elderly made retrenchment of the former relatively risk free. Moreover,

as McQuaig further notes, even among those who stood as defenders of Canada's social programmes there existed a willingness to entertain the targeting of entitlements. Why, it was asked, should "the wealthy banker's wife" (1993, p. 38) receive the same $34 dollar payment from Ottawa as the low income mother. Mulroney himself used a similar analogy to justify his cuts to the OAS (McQuaig, 1993, p. 38). Framed in these terms the issue become one of who deserved state entitlements against who did not.[13] This dichotomy between social programmes resembles that found in Britain between the public housing and Social Security.

What the above demonstrates is the Mulroney government's ability to act where there existed only a weak public consensus or where this consensus could be divided. It is clear that in the mind of the Government universality was not an across the board "sacred trust" but rather one that seemed to apply only where the Government felt it could not get away with increasing programme selectivity. This conclusion emerges strongly from the contrast between the OAS and child benefits and later health care.

6.4 Summary and observations

From this overview of the policy and political environment it is possible to make the following observations relating to the themes of this research. Firstly, it is clear that the Government's New Right leaning towards limiting public expenditures was a common principle linking the Mulroney government's policies in many fields. Thus, the

[13] An interesting sidebar to this study is the very different ways in which entitlement to benefits was debated by New Right government's in Canada and the UK. While in the UK much of the debate seemed to centre around the Poor Laws influenced difference between the deserving and undeserving poor, in Canada the debate focused around the deserving and undeserving rich. In these terms Canadian social policy activists fought to retain universal programmes for all Canadians irrespective of means while Government sought to remove benefits from those whose income, it was believed, made the benefit superfluous.

decisions to wind-up state corporations or reduce the size of the civil service were primarily justified in terms of the contribution these initiatives would make to deficit and debt reduction. The same logic of expenditure control was also utilized to justify the decision to curtail increases in the OAS.

Secondly, as I noted above, the Mulroney government inherited a welfare state which the Conservative Party had only a limited role in designing. Moreover, this welfare state was founded on principles which now seemed to the Government and its backers to be at odds with the fiscal situation in which Canada found itself. Minister Wilson, in particular, would use these "new economic and fiscal realities" to argue that Canada's social programmes would need to be re-evaluated and possibly redesigned. Thus, just like the British Conservatives under Mrs Thatcher, the Canadian Tories found themselves in a situation where they would have to deal with inherited policies but also inherited values attached to these policies and programmes. As the case of the deindexing of the OAS highlights, sometimes these inherited values are the ones which interfered with the Mulroney government's ability to begin wide ranging social policy reform. Moreover, many of these inherited policies contained an intergovernmental aspect which further reduced the manoeuvring room of the Tory government. In short, the Government was not only hemmed in by inherited policies and values, but also by the jurisdictional division of powers which meant that Ottawa funded programmes but had little impact in their design. This was the case, for example, in the area of welfare benefits.

Thirdly, the Government's cancellation of its decision to deindex the OAS is a good example of the difficulty of reversing the welfare state. In this instance, the Government was forced to reverse itself due to the wide public support which coalesced in defence of the OAS programme. Thus, as Therborn and Roebroek (1986) have

theorized, public opinion creates a protective buffer surrounding the welfare state and its programmes. But, what is interesting in this particular case is how OAS indexing was saved but the Family Allowance was not. The difference in this case lies in the differing status of the programmes. OAS is a truly universal programme, all Canadians will - upon reaching the age of 65 - receive the pension. Family Allowance, while also a universal programme, has a much different target group, that is persons with children. Moreover, while the OAS forms a significant part of the income of elderly Canadians the Family Allowance was not a minimal income guarantee programme. Thus, for activists and politicians it was easier to present the case of Canadians over 65 losing hundreds of dollars of their income over time, while the same case was more difficult to make for Family Allowance which only amounted to just over $300 a year. In short, the constituencies and the programmes were different - in the first every Canadian could see how the decision to deindex would affect them one day, while in the other this was not as readily imagined and the income value of the programme was not as dramatic.

The institutional dimension of the Mulroney government's decision to reverse itself on OAS deindexing shows how the supportive consensus acts to protect social programmes irrespective of the *loci* of policy hegemony. As the OAS is a solely federal programme one can readily see how the pressures exerted on the federal government prompted it to backtrack. But with EPF restraint the health service decisions occasioned by this policy were taken by another level of government. Yet, despite the fact that the EPF insulated the Mulroney Government from blame, it none the less felt under pressure to maintain some financial presence and further reaffirm the federal role in health. In short, although institutional circumstances provided an opportunity to cutback health funding it is also true that - as with the OAS - public opinion still weighed against radical

cutbacks. In this sense the jurisdictional division of power did not act as a damper to public opposition.

Another feature of the fight to save the OAS was the wide ranging coalition which formed in its defence. As I discussed previously, the genesis of the *Canada Health Act* was just such a coalition of interests forming to defend Medicare. In this instance the coalition of interests included representatives and groups from all sectors of Canadian society, from activists to business leaders. Although this coalition was more *ad hoc* and more ephemeral than the Canadian Health Coalition (CHC), for example, it shows a propensity in Canadian politics for coalitions of interests to form in defence of the welfare state.

Finally, in general terms, the social policy of the Mulroney government highlights an initial willingness to introduce radical policy change, although these were thwarted by political considerations and institutional limitations. As such, the Mulroney government's recourse to incrementalism in its social policies was a political compromise towards its overall economic and social objectives. Incrementalism will be a feature of the Government's policy with regards to the EPF which I discuss below.

CHAPTER SEVEN:

HEALTH POLICY UNDER MULRONEY, MEDICARE AND ITS FUNDING

7.0 Introductory comments

According to Manga and Weller (1991), while the Mulroney Conservative's claimed membership to the same type of conservatism as Thatcher and Reagan, the Canadian Tories were a quite different party. While the rhetoric was at times the same the actions were different. No sector bears this out as much as health care (Manga and Weller, 1991, p.210). Although the party was caught up in the New Right discourse of the period in health its policy pronouncements centred largely on the problems of the consumer's role in the cost escalation of health care. Measures to control this situation with regards to demand rather than supply and options such as user fees[1] were frequently mentioned by ministers, party activists and provincial Conservative parties. However, while present, this rhetoric was much less "virulent" than in the USA or Britain (Manga and Weller, 1991, pp. 213-214; also Winnipeg Free Press, 24 April 1991; Vancouver Sun, 16 April 1991).

The reality of the situation was that the federal government did not impose a radical reform agenda in health care, thus contrasting its actions with those of the British

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[1] User fees or charges and extra-billing have become synonymous in Canada although they refer to two very different things. The *Canada Health Act* defines extra-billing as "the billing for insured health services rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province or territory." User charges are defined in the Act as "any charges for an insured health service that is authorized or permitted by a provincial or territorial health care insurance plan that is not payable, directly or indirectly, by a provincial or territorial health care insurance plan, but does not include any charges imposed by extra-billing" (Canada, 1985a, Chapter 6, Section 2).

For the purposes of this research, as these terms have become interchangeable with the term user fees in the discourse of policy makers and observers, I will keep with this practice and, therefore, also refer to user fees, meaning user charges and extra-billing, throughout unless otherwise noted.

Tories (Manga and Weller, 1991, p. 216). Considering that the operation and administration of the Canadian health system is constitutionally in provincial hands, this should not be surprising. What the following pages will chronicle are policies which played to both the social and political consensus concerning Medicare as well as to the demands for fiscal changes made by business and other economically and politically conservative communities. Therefore on the one hand the Mulroney government would seek to stand in opposition to provincial recourse to demand-side measures such as user fees, while on the other it would curtail significantly the federal transfer payments for Medicare. This chapter will focus in the latter aspect of the Mulroney agenda and Chapter Eight on the other aspects of its health policies. What the following discussion makes clear is that the Mulroney government did not 'change' or radically reform the health systems of Canada. This situates the main contrast of my comparative study where a highly active policy sector in the UK is matched by much more limited activity in Canada.

7.1 Restraining the EPF

One of the first initiatives undertaken by the Government in an effort to mould policy to its neoconservative rhetoric was the *Ministerial Task Force on Program Review* (Nielsen, 1985) headed by Deputy Prime Minister Eric Neilsen (Manga and Weller, 1991, p. 214). If it was expected that the Neilsen Task Force would prompt a redrawing of Canada's health system its conclusions proved otherwise. While the Task Force observed that the provinces had not been able to control the escalation of health care costs, the Task Force believed this to be the result of the "public popularity of 'no-cost' (sic) health care," further concluding that despite this situation there were "no compelling program

reasons to reduce transfer payments" (Nielsen, 1985, p. 13). Moeover, the Report noted that one consequence of any policy of EPF restraint would be to "substantially reduce [the federal] role in Canada's health care system" (Nielsen, 1985, p. 13). As a consequence of this analysis the Nielsen Taskforce made a number of recommendations concerning the federal role in Medicare - including softening the dispositions of the *Canada Health Act*. However, these recommendations did not find their way into concrete government policies. The *Canada Health Act* was never modified, neither were user fees or large scale privatizations introduced. Thus, from its first careful steps in the health policy arena the constraints imposed by previous policy initiatives (inherited policy) were clearly visible to Mulroney government policy makers. Certain policy options were simply not available.

Once in office the Mulroney Tories did not wait long to begin their announced fiscal rebalancing. The EPF formula was altered three times in eight years beginning with the 1985 budget by Michael Wilson. These changes were unilateral and caught the provincial finance and health ministers largely by surprise. Jake Epp himself, the federal health minister, was forced to move from assurances that there would be no cuts to health transfers to the provinces to downplaying the significance of the first federal cut to EPF transfers in February 1986 (Debates, 23 November 1984, p. 540; Debates, 24 February 1986, p. 10884). Even after the May 1985 budget Epp held to this earlier position, "Le pourcentage de la contribution fédérale ne va pas changer... il n'est pas question de réduction"[2] although he also added that the size of the debt did reduce the federal government's "flexibility" (Le Droit, 14 June 1985). This reliance on the debt and deficit would be a recurring theme in the Government's defence of its EPF cuts.

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[2] Author's translation, "the percentage of the federal contribution will not change ... there is no question of a reduction."

Although deficit reduction marked all of Michael Wilson's budgets, the EPF itself was only restrained on three occasions spanning the life of the Mulroney government. Wilson first restrained the EPF in his first full budget of May 1985, a policy explained by him in terms of the need,

> to spread the burden of expenditure reduction fairly, the government will also be seeking to limit the rate of growth of transfers to the provinces to yield annual savings of $2 billion by the end of the decade (Debates, 23 May 1985, p. 5020).

The action which the Minister of Finance had undertaken was to reduce the EPF escalator by two percentage points beginning in 1986-87, thereby honouring his pledge to provincial finance ministers not to reduce the federal government's transfer in the current fiscal year (Thomson, 1991, p. 23; Debates, 23 May 1985, p. 5020). While the EPF continued to be tied to provincial economic and demographic growth, the per capita growth would be two percent lower than under the original 1977 formula (Madore, 1991, p. 9). Despite the cut Wilson claimed there would be no 'absolute' reduction in the transfer and transfers to the provinces would continue to grow, representing in 1990-91 the "same share of total program expenditure as they do today" (Debates, 23 May 1985, p. 5020). A promise which he was unable to uphold. Together with *A New Direction for Canada* Wilson's budget established the grounds for the Government's fiscally driven agenda as well as making government "more efficient and effective" (Debates, 23 May 1985, p. 5020). Themes which also resonated across the Atlantic. Wilson's first budget also took a stab at the OAS and Family Allowances where his restraint measures were partially endorsed (Bercuson et al., 1986, p. 118).

After his inaugural budget's measure to limit the growth in the EPF, Michael Wilson refrained from future restraint affecting health until the Government's second term although following budgets continued to display a desire to reform social

programmes based on the "twin tests of social and fiscal responsibility" (Debates, 26 February 1986, p. 10983). Moreover, the effect on the provinces of the 1985 budget would only become felt in the following fiscal year. The hallmark of Wilson's strategy with regards to EPF restraint was to preconize changes which were relatively invisible but none the less automatic. Changing the formula by which the EPF was calculated was a slower deficit cutting tool than direct cuts, but it was politically more acceptable. With Wilson's approach to EPF restraint cuts were never immediate but would rather come in over time as the effect of the adjustment to the EPF formula would slowly chip away at the Government's contribution.

With the politically divisive Free Trade election behind it the Government returned to high visibility policies and once again restrained the EPF. This time Wilson reduced the EPF escalator by one point beginning in the 1990-91 fiscal year - thereby reducing the escalator by 3 percentage points in five years of government (Thomson, 1991, p.23; Fréchette, 1994, p. 5). However, this action by the Minister would be overtaken by measures contained in his following budget.

In 1990 the knife was set aside in favour of the icebox as the Minister of Finance announced that the per capita entitlements of the EPF formula would be frozen (Debates, 20 February 1990, p. 8599). The Government also "introduced a transfer growth rate equal to that of the growth rate of the population of each province, i.e. 1.0% at the national level" (Madore, 1991, p. 9; Fréchette, 1994, p. 5). The EPF freeze was to be part of a proposed two-year expenditure restraint programme which would affect most areas of government operations with the exception of income support programmes for seniors, families and veterans, UIC, equalization payments and CAP payments to lower-income

provinces (CAP payments to 'have provinces' were frozen at their 1989-90 level) (Debates, 20 February 1990, p. 8599).

Although a constant theme, federal pronouncements tying together the issue of federal fiscal constraint to that of the provincial dimension of public finance became more explicit in the Government's public statements following Michael Wilson's February 1990 budget. Responding to opposition questions regarding his budget the Minister stated his commitment to the "best health care program that we can have in this country" had not wavered nor had been changed by his fiscal measures. However, he added that the federal government was seeking co-operation from the provinces to "share in the solution to a national problem" (Debates, 22 February 1990, pp. 8689-8690). Wilson also decoupled the EPF transfers from the debate over the state of the health system by referring to the fact that they were "unconditional" and therefore provinces could use EPF transfer funds for any programme. Provinces, he argued, were not "[asked] to do anything more than we [the federal government] are prepared to do ourselves" (Debates, 22 February 1990, pp. 8689-8690).[3]

The February 1991 budget found Canada in the midst of a recession from which it would not fully emerge by the end of the Mulroney government. Inflation became Wilson's priority issue; the deficit, in so far as it affected the inflation rate, was also given strong mention in his budget. Although the 1991 budget did not directly touch upon the EPF the Government's expenditure control programme, announced in the 1990 budget, was extended until the 1994-95 fiscal year (Debates, 26 February 1991, p. 17689). Wilson acknowledged that his budget policies were having important implications for the

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[3] A parliamentary report (Canada, 1991a) issued in 1991 highlighted the difficulty for the federal government to act in this area without taking into consideration the role of the provinces. The Report also points to the difficulties inherent in establishing the levels of funding required to maintain Canada's health system.

federal-provincial fiscal arrangements. These programmes, he stated, accounted for 90% of all moneys transferred by the federal government to assist the provinces in providing necessary services. But faced with a $39.6 billion expenditure, Wilson stated that federal transfers were too large to be exempted from the Government's expenditure restraint initiatives. "The deficit is a national problem and it demands a national solution." But, Wilson added, "the government wasn't asking more of the provinces than it is doing itself" (Debates, 26 February 1991, p. 17695). Wilson's 1991 budget speech also acknowledged for the first time that the Government's budgetary and fiscal policies were eroding the Government's ability to uphold the *Canada Health Act*. Wilson promised to address this problem by introducing legislation that would ensure that the federal government continued to have the means to enforce the Act's five conditions. "The principles of the *Canada Health Act* will not be compromised" (Debates, 26 February 1991, p. 17695).

Wilson's last budget, achieved the remarkable feat of tying his successor - and any government elected in the next election - to his expenditure control plan. Thus the direction of the Government's next budget, by Minister Don Mazankowski, and the federal Tories' fiscal agenda to the next election had been mapped out by Wilson in 1991 and, consequently, Mazankowski's two budgets stayed to the course established by Wilson. Expenditure control was to be broadened, but the Government was exempting major transfers to the provinces this time. Mazankowski, like Wilson before him, refused to dissociate social policy from the broader economic objectives of the Government stating: "Building a healthy economy is good social policy and good social policy helps build a healthy economy" (Debates, 25 February 1992, p. 7600).

The timing of Wilson's decisions to alter the EPF are illustrative of the politics of the period. In all cases the more drastic changes to the EPF were time-delayed. As such the Government would face the opposition and public flak well before the measures actually took effect. Additionally, it is interesting to note that the high visibility changes to the EPF formula occurred in the early budgets of each term (1985 and 1989) rather than budgets closer to elections where the political risks were heightened. This also partially explains Mazankowski's decision not to pursue EPF restraint. Thus, in effecting policy change it appears that the Mulroney government preferred to initiate risky policies when its political capital was at its highest - right after an election - and then it still chose a path which delayed the effects of its policies. By contrast, the Thatcher government's policies appeared to bear the brunt of opposition concurrently with the policy drive, although it too preferred to act when its political capital was highest.

While the restraint decisions came from Finance, it was none the less left to the health ministers to justify and defend the effect of Wilson's EPF restraint on Medicare. Jake Epp for example favoured a strategy which emphasized the continued federal support for Medicare. In 1986 for example Epp noted that despite the change in the EPF formula in 1985 the transfers projected to the provinces would increase from $65 million to $90 million; "[provincial governments] can maintain their health programs within those constrictions" Epp stated (Debates, 24 February 1986, p. 10884). At other times Epp would put the blame for health service cutbacks squarely on the provinces (Debates, 25 February 1986, p. 10993), thus deflecting the issue of the federal government's traditional contribution of near fifty percent of the costs of Medicare. It was also Epp who first suggested that poorer provinces should look to equalization payments to make up the "deficit" in health care (Debates, 10 June 1986, p. 14165). In other words, the

provinces hard done by the federal decision to restrain the EPF should raid other transfers to make up the short fall. In short, Epp's statement was an admission that Ottawa was negatively affecting the delivery of health services and, more interestingly, that the provinces should now seek to make up any shortfall in the health transfer with other sources of revenue. One can readily imagine the domino effect created by this thinking whereby the provinces would have to continually skim from other transfers, some also affected by restraint, to make up cuts in the EPF.

Rather than challenge the provinces Perrin Beatty rationalized the federal government's decisions in terms of the need to lessen the fiscal burden of debt and deficit. For example, following the 1991 budget Beatty would link the future of social programmes in general to the overall issue of fiscal policy. The real threat to social programmes was not the Government's steady cuts to transfers but rather the erosion of the federal government's spending capacity caused by having to devote almost one-third of its revenues to paying the national debt (Debates, 28 February 1991, p. 17781). Cash transfers to the provinces were increasing, the minister argued, and Beatty also played on the overall insignificance of the federal transfer by noting that these represented only one-half of one percent of provincial revenues. As Beatty stated: "To suggest that this [reduction on transfers] was the death knell of Medicare was ... scaremongering" (Debates, 27 February 1991, pp. 17705-17706). Moreover, Beatty returned to the argument that the federal government was asking no more of the provinces in its fight against debt and deficit than it asked of itself (Debates, 27 February 1991, pp. 17705-17706; 4 March 1991, p. 17899). For example, Beatty stated, while federal transfers to the provinces would rise by 3.7 per cent, the federal government was restraining its own programme expenditures to an increase of only 3.2 per cent. The

Minister of Finance for his part, asked if he did not worry about the impact on health services of his decision to control expenditures stated,

> [...] I think my honourable friend has to balance the pressures on our health care systems, our education systems, as well as the pressures on the total finances of the country, federal, provincial, and municipal (Debates, 4 March 1991, p. 17899).

Benoit Bouchard, who replaced Perrin Beatty, did not much alter the script in use since 1984. The Government remained committed to the health care system but threw a line to the provinces seeking co-operation in the face of the pressures of technology, demography and public expectations. However, "it would be a dillusion (sic) to believe that governments, ..., will be in a position to allocate substantial new financial resources to cope with the ... increase in costs; Canadians are well aware of this" (Bouchard, 1991a). Federal-provincial co-operation would be the new order of the day, but no derogation to the *Canada Health Act* was allowed nor new money committed (Debates, 26 February 1992, p. 7638; Bouchard, 1991b; Bouchard, 1991a). Don Mazankowski would repeat this federal position. Although provincial spending on health was increasing the size of the federal government's deficit did not permit Ottawa to increase its share of the costs (Debates, 18 February 1991, p. 16111; Globe and Mail, 18 June 1992). Provinces would have to look within their own resources to fill the gap or cutback services, which is precisely what occurred across Canada as province after province engaged in reviews and reforms of their health systems (see Health Canada, 1994, p. 8; also Angus, 1994; Hurley et al., 1994).

Thus, in terms of its pronouncements on financing the federal Conservative government had moved from claiming to continue to share in funding the system to stating that it could not return to the principle of the even split between provincial and

federal funding of the health system. An ancillary issue, and in some quarters more important one, was how far the federal government was willing to go in defending the national standards for health care as enshrined in the *Canada Health Act*.

7.1.1 EPF restraint: Effects, obstacles, and opportunities

It is typical of the Canadian federal system, with its constitutionally defined division of power, that the issue of health policy would pit the federal government against its provincial counterparts in a policy sector, health care, which is clearly within provincial jurisdiction. It is further paradoxical that this area of conflict would arise in a sector where the federal government pushed its way in using its spending power and appeared, according to many, under the Mulroney Tories, to want to vacate. This is one interpretation of the federal government's decision to restrain the EPF. Another is that the federal government was intent to pursue a policy aimed simply at redressing the fiscal balance in its budget. It is therefore useful to consider the effects and possible explanations for the federal government's chosen course of action.

It is a fact of the Canadian health insurance system that while the federal government contributes approximately 40 per cent[4] of the funds for provincial health programmes, it has absolutely no control over how the money is spent. Canada's social programmes were largely born out of a federal-provincial consensus that a need existed which government should address. Unable to fund the programme themselves, the provinces generally welcomed the federal government's financial assistance, although they often resented the federal government's desire to involve itself in setting 'national

[4] Under the original 1977 EPF formula the federal government provided approximately 50 percent of the funding. For example, in the case of Québec, as a consequence of the Government's changes to the formula and funding freezes, the federal share was down to approximately 33 percent from 45 percent before the Wilson restraint policies (personal interview CDN 3).

standards' for these programmes. As former Ontario Deputy Minister Michael Butler (1993) notes, these fiscal relations - and their attendant level of inter-governmental co-operation - "dissipated [and were] replaced by a climate in which the provinces [felt] their funding partner has backed away from a partnership model which enabled the establishment of modern social programming" (Butler, 1993, p. 22). The explanation for this change Butler finds in the federal government's decision to restrain its expenditures "as a necessary correction to years of fiscal imprudence, particularly as regards provincial spending on social programs" (Butler, 1993, p. 22). In short, while the real job of reforming health policy was outside the federal government's ambit, it chose a course of fiscal policy which may have hastened these reforms - although this cause and effect linkage is difficult to establish.

Although there is an inter-governmental aspect to the federal government's fiscal initiatives, the main policy factor explaining Ottawa's policies is "the fight to reduce the deficit ... for that reason the changes [in EPF] must be viewed as a search for a new *economic* balance between [both levels of government]" (Fréchette, 1994, pp. 6-7. Emphasis in original). This new balance, driven by the Mulroney deficit reduction agenda would also entail a shifting of a greater share of the costs for Medicare to the provincial governments, a process known as deficit off-loading (Boothe and Johnson, 1993).

As Table 7.1 below shows, although the amount of dollars transferred by the federal government continued to increase, the rate of growth in the transfer was slowed considerably by the Wilson budgets. As a result the cash portion of the EPF was steadily eroded and with it the federal government's capacity to enforce the *Canada Health Act.* In all these restraint measures contributed to a $41 billion reduction in federal cash

transfers to the provinces - a cash shortfall the provinces had to make up for out of their own resources (Boothe and Johnson, 1993, p. 3). This shift from federal to provincial resources is highlighted in Table 7.2 below. As shown, between 1985 and 1993 "the provincial share of absolute dollar change per capita provincial health expenditure was greater than the federal share" (Health Canada, 1994, p. 17).

Table 7.1
Federal Transfer for Health, 1985-1993 (in actual millions of dollars)[5] and per cent annual change.

Year	85	86	87	88	89	90	91	92	93
Transfer	10.9	11.7	12.4	13.1	13.9	14.3	14.6	14.8	14.9
Change in %	7.77	6.82	5.95	5.75	6.31	2.8	3.38	1.82	1.12

(Source: Health Canada, 1994, Tables 14a and 14b)

Table 7.2

Dollar change in Real Per Capita Government Health Expenditures, 1975-1993

Year	85	86	87	88	89	90	91	92	93
Fed.	13	10	3	4	2	-19	-9	-12	-8
Prov.	15	46	26	30	41	34	59	-3	-4

(Source: Health Canada, 1994, p. 17)

The consequences of the federal government's funding decision were felt across the country as provincial governments attempted to hold their expenditures in check while at the same time maintaining a comprehensive health system which conformed to the *Canada Health Act*. It is at this time, and particularly in the latter half of the 1980s,

[5] Insured health services and extended health care component of EPF only.

that a growing number of provinces began to take liberties with the spirit, if not the letter, of the Act. At the same time, pressure began to be exerted on the federal government to completely vacate the health policy field - thereby returning it entirely to provincial control (Debates, 3 December 1990, 16097; Debates, 19 March 1991, 18653).

The provinces dealt with these federal reduction in health transfers in a number of ways including health system reform. Thus as Table 7.2 shows, between 1985 and 1991 provincial governments did little to slow the pace of their health care expenditures and largely absorbed the federal cuts. However, beginning in 1992 (a period of economic recession in Canada) the trend line points towards provincial reductions in health spending. Thus, while it is noted that all of the reform activity has been situated at the provincial level, the federal government's fiscal policies gave it a role in the genesis of these reforms (personal interview CDN 15). Across Canada the cumulative shortfall created by the federal restraint hit with varying intensity. The Ontario government, facing a cumulative shortfall of $18 billion in EPF, (personal interview CDN 14) noted, "[the] ministry faced a continuing recession, escalating costs, and cutbacks in federal transfers - all serious threats to the Medicare system ... of Ontario [...]. So, we took action" (Ontario, 1993, p. 3). Similar statements can also be found in the public documents of the provinces of Québec (1990, p. 8) and the Nova Scotia Royal Commission on Health Care (Nova Scotia, 1989), the latter noting that the federal government's cutbacks "exacerbated" the pressures on its health system (Nova Scotia, 1989, p. 30). As one Health Canada report noted,

> The control in the growth of federal transfers may have provided incentives for the provinces to reduce their health expenditures [...]. This trend line should be more evident in 1994 and 1995 when reductions in health expenditures announced by many provinces are to be realized (Health Canada, 1994, p. 8).

However, the cutbacks in EPF were not the only factors at play in provincial decision making, others included the 1980s economic recession which diminished the spending ability of the provincial government as well as the lack of linkage between the amounts devoted to health care and actual health outcomes. All of these factors - including EPF restraint - were leading provinces to consider new options for their health systems, but they found the federal government unwilling to budge on either the *Canada Health Act* or constitutional issues relating to health. Paradoxically at the same time as the provinces were pleading poverty a contrary view emerged, evident in the comments of former Ontario Minister of Health Dennis Timbrell (in Financial Times of Canada, 27 February 1989) and others (personal interview CDN 2; Hurley et al., 1994; Angus 1991 and 1994) that there was, in fact, enough money in the Canadian health system, what was needed was an examination of how it was spent. This theme was also noted in federal circles (Debates, 19 March 1991, p. 18656). The health system reforms initiated in some of the provinces focused on this issue by suggesting new administrative measures to increase efficiency and effectiveness in their health systems. However, despite this recognition by some provincial governments, calls for "the federal government to ... prevent the further erosion of its support [for Medicare]" (Provincial and Territorial Ministers of Health and Finance, 7 February 1989) were frequent (see also Telegraph Journal, 8 February 1989; Telegraph Journal, 7 February 1989). Additional expressions of the need for greater co-operation between both levels of government were also frequent during this period (Nova Scotia Royal Commission, 1989, p. 30; Provincial and Territorial Ministers of Health, 10 September 1987). This level of inter-governmental agreement among the provincial ministers was also one which resulted in rifts with the federal minister, particularly about funding (personal interview CDN 14).

Therefore, while the reductions in EPF were a contributing factor to provincial government's decisions to reconsider and reform parts of their health systems,[6] it is also true that underlying these initiatives were pressures unrelated to federal funding - pressures such as demographic change (Barkin, 1992). Although the federal government has, through the EPF and *Canada Health Act,* a critical role in defining the medical services which are to be provided to the Canadian population, it has very little role in defining the institutional structure which provides these services. Therefore, while it exercised a symbolic role in discussions surrounding provincial health system reforms, the reforms considered by provincial governments, models such as regionalization of hospitals or changes in the payment system of physicians, were beyond the ambit of Ottawa's jurisdictional reach. But, while reform activity was situated at the provincial level, the federal government's fiscal policies gave it a role in the genesis of these reforms (personal interview CDN 15; Health Canada, 1994, p. 8; Boothe and Johnston, 1993, pp. 6-9). Although federal restraint policies did prompt provincial reform initiatives it is important to treat each in isolation from the other. There was no federal-provincial agreement to institute planned health reforms as the very different routes taken by provinces highlights (Boothe and Johnston, 1993, pp. 6-9; Hurley et al., 1994; Angus, 1994). Thus, rather than target health specifically one must consider federal EPF restraint as part of a wider deficit fighting strategy. As one Finance official noted,

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[6] The view that the federal government cutback the EPF transfer in order to force the provinces to reform their health system can be exploded by two considerations. In the first, it is obvious from this research (particularly personal interviews CDN 1 and CDN 13) that the EPF, or rather health spending, was not targeted for restraint, but was ultimately controlled as part of a larger fiscal exercise. Secondly, the federal government continued to enforce and, as it did with C-20, signal a continued commitment to a federal presence in establishing national standards for health care. From these I submit that had the federal government's agenda been to force provincial health system reform this would have been more greatly facilitated through legislation or policies which would have opened up the full range of possible reforms to the provinces, through changes to the *Canada Health Act* particularly, rather than fiscal restraint.

> you look at budgets and major expenditures, some minor ones, and one of the huge, to the tune of $40 billion a year, is transfers to provinces, that's $40 billion out of total programme spending of about $120 billion. So, that is always on the table when you look at ways of dealing with years of debt (personal interview CDN 13).

Additionally, the federal government's decision to restrain its transfer was based upon 'cost driver' studies (Finance Canada, 1992) which showed that the fiscal capacity of the provincial governments was greater than that of the federal government. Off-loading, in these terms, was both politically and fiscally prudent for the Mulroney government. In total Wilson's EPF restraint policy shifted approximately $1.7 billion of Ottawa's deficit onto provincial governments (Boothe and Johnston, 1993, p. 6). In an environment where there appeared to be no 'fiscal room,' this was believed to be a better option than a recourse to increasing the federal government's debt and deficit (personal interview CDN 13). While it can be argued that the Mulroney government did have only limited room to manoeuvre as a consequence of the mounting national debt and spiralling deficit, it did have ultimate decision power over what areas were cut or restrained and which were not:

> [So] the government sets it's priorities and determines how it wishes to deal with individual sectors to which it spends, directly or indirectly, and the EPF funding was restrained. Growth was restrained then frozen (personal interview CDN 13).

The federal government's stake in the country's social system and fabric therefore becomes "[...] a matter of what place transfers occupy" in overall government priorities (personal interview CDN 13). Considered in isolation the figures presented in Tables 7.1 and 7.2 might lead to the conclusion that a broad neoconservative assault on the financial basis on Medicare had taken place. In fact, rather than a New Right induced radical restructuring of Medicare the figures (especially Table 7.2) highlight the overall moderation of the Mulroney government. This can be surmised from the funding changes which, until 1992, did not imperil the provincial governments' ability to make up the lost

federal funds. In short, the Mulroney government's policies made a significant impact on Ottawa's financial position but much less so on health care itself.

Although they bore the brunt of the federal decision to restrain EPF, provincial officials understood this federal policy as one fiscally rather than socially driven. Federal cuts were therefore seen as part of the larger deficit reduction drive and, unlike changes made to the method of funding the health system in 1977, the Tory decision to reduce EPF contributions was only motivated by a desire to control the deficit[7] (personal interviews CDN 2; CDN 3; CDN 15).

The above raises the question of why the federal government did not further disengage itself from its financial obligations to the provinces. For example, why did the Mulroney government not unilaterally redraw its role in social programmes funding as did the Trudeau government in 1977. As I noted above, as the odious decisions in health reform (e.g. closing hospitals, delisting treatments) fell on the provinces, it would appear that fiscal disengagement would be a relatively risk free endeavour for the federal government. This issue touches on two aspects of my analysis. Although institutionally Ottawa's role was limited to funding a portion of Medicare the federal government continued to occupy an oversight role in the system. The legislation enabling the provincial plans was federal as was the *Canada Health Act* - the passage of which proved cathartic in Canadian social policy circles. The CHA had become a symbolic barometer of the state of Medicare. Therefore, for the Mulroney government to fully end the EPF transfer would have likely raised the ire and protests of countless Canadians and, as the reversal over OAS deindexing showed, the Mulroney Tories were particularly sensitive to

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[7] It is worth noting here that the provincial treasurers were also facing up to the need to control the escalation of their budgets and while no warning of impending federal cuts were given to his provincial counterparts, it was suggested that they were well aware of the overall strategy of the federal Minister of Finance as this was a strategy close to their own (personal interview CDN 2).

public opinion in matters of social policy. In short, a complete federal withdrawal would have entailed 'blame-taking' rather than the "blame avoidance" (Weaver, 1986) which the Mulroney Tories preferred. Therefore, while Ottawa pushed the fiscal envelope it held back from more drastic measures. This validates the thesis that a supportive consensus - especially where the programmes are universal in scope - can protect social programmes from rollback. In this instance public opinion also included the pressures exerted by consumer and provider groups such as the Canadian Health Coalition (CHC) and the Health Action Lobby (HEAL).

Another set of pressures limiting the federal government's ability to drastically curtail the EPF was the pressure exerted by provincial governments. This was especially important to a government which set among its primary objectives to ameliorate the climate in federal-provincial relations. Therefore, although measures were taken with regards to EPF, I suggest that these were limited by the fear of provincial opposition. These were pressures unique to the Canadian case as the British government of Mrs Thatcher did not have to contend with sub-national levels of government in setting its policy goals.

But, while critically concerned with the state of its own budget deficit, the federal government was also critically aware that it's budget cuts were endangering its leverage in the health system, thus the need to find a new way to enforce the *Canada Health Act.*

7.2 Summary and observations

It is the Mulroney government's treatment of the fiscal aspects of Canadian health care that is the most important as it is this policy which most greatly affected the actual level of services provided by the provinces. However, it must also be recognized that

there is not necessarily a direct link between policies made in Ottawa and policies made in the provincial capitals. For the federal government EPF was a handy device as it created an arms length relationship between funding and services. Moreover, as a block funding programme, the EPF did not mandate the provinces to operate their health systems in particular ways - that is with the exception of the conditions outlined in the *Canada Health Act*. The EPF, therefore, gave Ottawa the chance to play the system in two ways, it could either be very involved - as it was during the passage of the *Canada Health Act* in 1984 - or it could take a hands off approach and treat Canada's health system solely as a resource management issue not within its constitutional prerogative - as it did under Mulroney.

This more traditional reading of constitutional jurisdictions is further interesting when one considers the manner in which Ottawa was trying to recast its role in the health system. Its call for a new balance to be set between the pressures exerted on the health system and the fiscal situation of the Government highlights this issue. While, demographic and cost pressures on the health system were felt entirely by provincial governments part of the financial resources with which these pressures were to be met were determined by Ottawa. This position on the part of the federal government was only possible due to Canada's institutional regime. Thus, to repeat a previous observation, the Mulroney government inherited a health policy and related values (such as universality and free access) but also inherited policy tools, such as the EPF, which permitted it to work around the inherited policy and values. In this instance very few veto points could halt its policies.

On the wider spectrum, the manner in which the EPF was used to address Canadian health policy also highlights the difficulty in reversing Canada's welfare state.

It was constitutionally and institutionally possible for the federal government to walk away completely from the health domain. This was, in fact, a frequent demand of some of the provincial governments which objected to Ottawa's involvement through the *Canada Health Act*. But, the Mulroney Tories did not walk away. Part of the explanation for this may have to do with the wide support which Canada's social programmes have among the public. It is no coincidence that the Mulroney Tories, then in opposition, sided with the Liberals in 1984 to pass the *Canada Health Act* and that later Brian Mulroney himself (and later his ministers) would fall over themselves to make motherhood statements about the principles of Canadian social policy being "sacred trusts." The manner in which Tory ministers made certain that EPF restraint measures be seen as fiscal measures which did not endanger Medicare further supports this case. However, this strategy - although fiscally driven - points to a desire on the part of the Mulroney government to pass the odious decisions in health care reform to the provincial level. As such the Mulroney government was practising both pragmatic politics in terms of its own electoral agenda and the "politics of blame avoidance" (Weaver, 1986), that is a politics based on claiming the successes in its fight against inflation and the deficit while avoiding blame for decisions such as cutbacks and reforms in provincial health systems.

However, the fact that the Mulroney Tories stood in support of parts of the welfare state and its potential extension does not make of them closet social democrats. It is clear that the logic and rhetoric of their policy pronouncements belonged to the same school as those of Mrs Thatcher. As such, Mulroney's support of the welfare state was for political appeal - which is, it is important to note, the sole *raison d'être* of a political party. Key to his New Right allegiance was the placement of public expenditure restraint

foremost among other policies. This can be seen in the role of the Nielsen Task Force but also in *A New Direction for Canada* which made social policy subservient to fiscal goals. In this sense, the mission of the Government was no longer to ensure individuals equality of circumstance but rather to ensure a sound fiscal environment for Canadians and Canadian business. In other words, the problem faced by Canada was not of lack of health care but rather of lack of fiscal balance and only once the latter was addressed could governments return to focusing on the former. Interestingly, the divergence between Canada and Britain is largely centred on this fiscal agenda for while Mulroney chose a primarily fiscal device in dealing with health under Thatcher the funding for the NHS was not similarly constrained.

Also noteworthy is the incremental nature of the Mulroney government's policies. Thus, one can see in the successive measures to restrain the EPF the policy making designs proposed by Wildavsky (1964) and Lindblom (1959) and others (Weiss and Woodhouse, 1992). While the Mulroney government cannot have been said to have muddled through, it is none the less true that it proceeded slowly and by smaller measures to achieve its goals.

However, as I discussed above it appears that the EPF was less of a social policy device aimed at changing either programmes or behaviour and mostly a fiscal device. Which is not to say that EPF restraint did not have an effect of Medicare. Other devices most closely linked to health are discussed in the following chapter.

CHAPTER EIGHT:

BEYOND THE FISCAL AGENDA

8.0 Introductory comments

The previous chapter dealt primarily with the fiscal policies of the Mulroney government in so far as these impacted on Medicare. Due mostly to the institutional nature of the Canadian health care system it is at this fiscal level that one can point to a 'Mulroney health policy,' although this was a health policy only by default - health was only one of several sectors of federal government spending to feel restraint. In terms of the other areas of activity that concern health the Canadian case shows a remarkable lack of activity at the federal level, in striking contrast to the British case. The reason for this is again the result of institutional factors. While the Thatcher era saw several initiatives discussed and implemented - for example the 1982 reorganization and the Griffiths Reforms - in Canada measures such as these were simply outside of the federal ambit. As a solely financial partner in Canada's health system the federal government does not have at its disposal the same panoply of policy instruments which were available to the provincial governments or the British government, although Ottawa's financial decisions did make an impact on provincial policies. Moreover, as the guarantor of the *Canada Health Act* the federal government had a tremendously important role to play in defining the standards for medical services in Canada - despite the fact that their administration and provision fell to the provincial level. This role is highlighted by the passage of Bill C-20 which I discuss below. Thus, unlike my discussion of Thatcherist health policy this chapter will deal mostly with the consequences of inherited policy on the activities of

the Mulroney government. Additionally, I will consider how a mature and apparently irreversible sector of the welfare state fared under a government of the New Right.

It has been my contention in relation to the British case that the NHS benefitted from popular attachment which limited the ambit of policies introduced towards its reform. I have linked this theoretically to the Therborn and Roebroek's thesis of welfare state irreversibility. Similarly, one element which runs throughout the discussion of the Mulroney government's health policy is the existence of an equally strong commitment by Canadians to Medicare. While in Britain around two-third of respondents to the 1987 Social Attitudes Survey supported a universal NHS (Bosanquet, 1988, p. 97) in Canada support for universal Medicare hovered between 80 and 90 per cent.[1] Therefore, it is clear that any federal policy concerning health would have to consider this supportive consensus concerning Medicare, a consensus that suffused all aspects of federal health policy.

8.1 Mulroney policy and the *Canada Health Act*

In Canada adherence to, and enforcement of, the *Canada Health Act* has become to many the symbolic barometer of the state of Canada's health system. Because of this the federal government's enforcement of the Act has been closely monitored by provincial governments, health activists and interest groups. Although the Act was passed under a Liberal administration it fell to Brian Mulroney's Conservative government to apply its

[1] These figures are from confidential documents released to the author under the understanding the their source was not to be cited. The 80 per cent figure is from a 1992 poll conducted for the Department of Health and Welfare which found that 81 per cent of Canadians supported Medicare as a universal social programme. The same survey shows approval for the federal government's handling of health care to hover around 70 per cent between 1985 and 1991, but falling to 53 per cent in 1992 when most of the provinces were beginning the process of adapting their health systems to the federal cuts. The 90 per cent figure is from a ministerial briefing document relating to a 26 October 1995 article in the *Globe and Mail*, this document points to support for universal health care exceeding 90 per cent in 1991.

conditions. Prior to its election the Mulroney government had adopted the position of defender of the Act and Medicare in general. A stance which limited the Government's policy options in the area of health. Despite this commitment the Conservative Party tended towards market solutions and individual responsibility as a means of dealing with the escalating cost of health care. Among Conservative party members user fees were a favoured policy option to address the pressures on Medicare (Manga and Weller, 1991, p. 214; See also Perlin, 1985). As an added benefit these same Conservatives saw user fees as a means to disengage the federal government from a hefty public expenditure programme at a time when its main policy objectives were deficit and debt control through restraint and trimming of public expenditure. Moreover, as the party had pledged to ameliorate federal-provincial relations, the federal ban on user fees, a measure which had been opposed by all the provinces and territories in 1984 (personal interview CDN 14; also Bégin, 1988) was seen as an irritant in intergovernmental relations which the new Government could do without. However, the Government had painted itself into a corner with Mulroney's public commitment to social programmes and the principle of universality. How the Mulroney government navigated these conflicting pressures is the theme of this section.

The promulgation of the *Canada Health Act* in 1984 was thought to have put to rest the option of user fees as a mechanism to control demand and expenditures for health services. However, despite research which demonstrated without doubt that user fees did not, in fact, affect the utilization rate of services or health system expenditure (see Vancouver Sun, 16 April 1991; personal interviews CDN 1; CDN 5), user fees were a perennial on the political landscape - particularly among Conservative backbench MPs and supporters and others on the Right - although this option was never seriously

entertained by Mulroney government ministers or the Prime Minister (personal interview CDN 1).

Returning to Döhler's discussion of inherited policies acting as a brake to sharper reforms of the NHS, in Canada the *Canada Health Act* became such a brake to future policy change. The Act defined in legislation the right of every Canadian to free and universal access to health care irrespective of region, income or status. The very process leading to the Act's passage, followed by provincial implementation of the Act's disposition's, was a crucible in the history of Canadian social policy.[2] In the same way that the EPF created a policy tool which the Mulroney government was able to utilize to restrain its contribution to health the Act created a set of values and policies which limited federal action. Thus, throughout the period of the Mulroney government there were sometimes strident debates about the Act, its dispositions and enforcement.

The Act itself works on a penalty principle. Provinces that do not uphold the Act have their transfer withheld (Canada, 1985a, Chapter 6, section 20). Thus it was that during the Mulroney government there were several internal and external debates surrounding the applicability of certain dispositions of the *Canada Health Act*. The discussions concerning user fees, for example, masked a larger debate about the decommodification of medical needs. Within the Conservative Party two tendencies coexisted, one which supported the introduction of user fees and the other, lastly championed by Benoît Bouchard and the so-called Red Tories, which steadfastly opposed these. Interestingly, this split mirrored that split between the business-liberal and the Tory traditions in Canadian Conservative ideology (Campbell and Christian, 1996, pp. 45-47). The latter group tending to look at the problems in the health system not as

[2] It is no accident that Canadians continue to rank Medicare as the key defining characteristic of the nation (Maclean's, 1 July 1994)

linked to funding levels but rather to how resources were used within it. Thus, when the issue of user fees was brought up in Cabinet, which was not frequently due to the Prime Minister's own dislike for the option, the issue was quickly quelled. Moreover, especially in the latter years of the Government's mandate the Minister of Health and Welfare was in the hands of a senior Cabinet minister who had the ear of the Prime Minister. This alone accounted for the continued hard opposition to the discussion of user fees in caucus and Cabinet (personal interviews CDN 1; CDN 5).

One suggested way of determining how strongly the Tory government enforced the *Canada Health Act* is to contrast its record with that of the Liberal government elected in 1993. The new Minister of Health, Diane Marleau, quickly announced her government's intention to tighten the enforcement of the Act and she acted decisively against long standing infringements of the Act by Alberta, Québec and British Columbia (Personal interview CDN 8; Health Canada, 19 May 1994; Health Canada, 6 January 1995).[3] While it would be an overstatement to say that the Tory ministers did nothing, the Mulroney government was not the most diligent in this particular area of federal-provincial diplomacy. While the Ministers of Health and Welfare under Mulroney did write to the provinces, as stipulated in the legislation, to state their concern about possible contraventions of the Act, at no point did these lead to further action by the Minister. No province saw its transfers withheld after 1987 - a course of action which the new Liberal Minister took weeks after taking office (personal interviews CDN 9; CDN 8. See also HWC, all years 1988 to 1992).

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[3] For example, in May 1994 Ottawa deducted $1.734 million for its transfer payment to British Columbia as penalty for the province's tolerance of extra-billing for insured medical services in 1992 and 1993 (Health Canada, 19 May 1994). In January 1995 Minister Marleau wrote to her provincial and territorial counterparts to outline her intention to strictly enforce the *Canada Health Act* in the future (Health Canada, 6 January 1995).

As the Mulroney government proceeded to restrain federal contributions to health care the issue of its commitment to the *Canada Health Act* gained in salience. The consequences of the federal government's funding decisions were felt across the country as provincial governments attempted to hold their expenditures in check while at the same time maintaining a comprehensive health system which conformed to the Act. As noted previously in Chapters Seven and Table 7.2, while at first the provinces made up the federal shortfall from within their own resources, by 1990 this was becoming an increasingly difficult position to hold. It is at this time that a growing number of provinces began to take liberties with the spirit, if not the letter, of the Act. At the same time, pressure began to be exerted on the federal government to completely vacate the health policy field - thereby returning it entirely to provincial control (Debates, 3 December 1990, p. 16097; Debates, 19 March 1991, p. 18653).

Underlying the federal government's policy regarding enforcement of the Act were two apparently contradictory goals, ameliorating inter-governmental relations and restraining federal transfer payments. Thus when Jake Epp, wrote to his provincial counterparts in 1994 he described his main priority as the need for a more conciliatory atmosphere in federal-provincial relations in matters relating to health funding and the health system in general (personal interview CDN 9; see also Toronto Star, 18 September 1984). While committed to the ban on user fees Epp was also willing to show some "leeway in interpreting the Act" (Toronto, Star, 18 September 1984; see also Debates, 9 December 1987, p. 11625). Thus, under Jake Epp the federal government discouraged provincial recourse to user fees although Epp's 'leeway' was interpreted by provincial government's as permission to whittle away at the health system by delisting a variety of services. It is further interesting to note that in 1991 Epp, while no longer health

minister, would himself come out in support of user fees (Winnipeg Free Press, 21 April 1991). Epp's successor, Perrin Beatty, stayed close to the Government's public line on the issue of safeguarding Medicare, particularly with regards to the issue of undermining the national standards which the *Canada Health Act* established (Debates, 3 December 1990, p. 16097).

As a political perennial, raised by either the CMA or the provinces, the debate over user fees extended into Benoît Bouchard's stewardship of the health portfolio. The appointment of Bouchard also marked a change in style from his predecessors. Although at first Bouchard wavered between leaving the door open to user fees and maintaining that Medicare was "sacred" (Winnipeg Free Press, 24 April 1991) he soon struck a more definite position against any derogation to the *Canada Health Act* than his predecessors (personal interviews CDN 5; CDN 15; CDN 11; CDN 9; Calgary Herald, 12 November 1991; see also Bouchard 1991c). To Bouchard universality and affordability were the cornerstones of Canada's health system and "[they] will not be challenged in anyway" (Bouchard, 1991b). However, Bouchard acknowledged that pressures were building on the health system and that the federal government needed to co-operate with the provinces in order to find the appropriate solutions (Bouchard, 1991b). Looking to the future Bouchard warned,

> Nevertheless, our health system is required to evolve, and probably to undergo transformations, because the challenges it is faced with are real ones and that a refusal to respond properly to them would, before long, lead to a breakdown in the quality of care and possibly in the principles of universality and accessibility (Bouchard, 1991a).

User fees had been fully rejected by Bouchard as he returned to the Government's earlier position that any form of fees for health services was a contravention of the Act and would be dealt with under the Act's penalties. His first target was a reform drive

calling for a $5 fee initiated by the province of Québec (Le Devoir, 25 May 1991). In fact Minister Bouchard would set Medicare aside from other social programmes as one which should not undergo any change to its principles and on one occasion referred to the federal government's role as that of "Medicare's (sic) guardian" (Bouchard, 1991c). A position which stood opposite to that of a growing number of members of his own party and later, candidates to succeed Brian Mulroney as party leader (Bouchard, 1991a; La Presse, 13 May 1993).

This discussion of the Tory government's application and enforcement of the *Canada Health Act* would not be complete without a consideration of the mechanisms contained in the Act which define the role of the federal government. If, as I have argued above, one accepts that the Mulroney government was selective in enforcing the Act due to constraints of ideology and institutions (federal-provincial relations), it is also true that it was possible for the Tories to act in this manner because of the way in which the penalty system of the *Canada Health Act* comes into force. As drafted and implemented the Act is largely discretionary and is based upon the need for the Minister of Health and Welfare (after June 1993 the Minister of Health) to form an opinion on the existence or not of a breach of the Act. Should the Minister decide that a breach has taken place he informs his provincial counterpart that action will be taken if the breach is not corrected. It is only after the Minister has communicated to his provincial opposite that the penalty mechanism of the *Canada Health Act* comes into play. However, as the process requires a ministerial directive, based upon an 'opinion' on his or her part, if there is reluctance on the part of the Minister to form such an opinion then the whole of the *Canada Health Act*

becomes unenforceable (personal interview CDN 5; Canada, 1985a, Chapter 6). The Act is therefore not based upon administrative decisions but on political ones. The desire for the Mulroney government to ameliorate its relations with the provinces - especially at a time of constitutional renewal - could offer a Minister of Health and Welfare a powerful incentive to be indecisive in forming 'an opinion' about a breach of the *Canada Health Act*.

Another factor on which the effectiveness of the *Canada Health Act* is predicated is the requirement that the federal government maintain a sufficient financial stake in the health system to enable it to use the threat of withholding transfer funds as a means of inducing provincial compliance with the Act. Despite the reassurances of successive health ministers, it became apparent that the fiscal restraint policies pursued by the Mulroney government were limiting its ability to enforce the *Canada Health Act*. Michael Wilson himself acknowledged that the EPF restraint measures that he had instigated had raised "concerns about the ability of the federal government to continue enforcing the *Canada Health Act*" (Debates, 26 February 1991, p. 17695). Under C-20, the *Budget Implementation Act* (Canada, 1991b, Chapter 51) the federal government gained the legislative authority to withhold any amount transferred to the provinces as a penalty for transgressions of the *Canada Health Act* (Finance Canada, 1994, p. 20).[4] Meaning that any transfer, be it for equalization, the CAP, or a regional development transfer, was now fair game for garnishment should a province contravene the Act. By introducing C-20 the Mulroney government was responding to public and interest group

[4] To remind the reader, the federal government transfers funds to the provinces under three main programmes: Equalization, Established Programs Financing and the Canada Assistance Plan. In addition, a number of other transfers exist which are tied to specific programmes such as official languages in education, young offenders or infrastructure improvements. These last transfers totalled approximately $4.7 billion annually (Finance Canada, 1994, p. 27).

pressure which clamoured for the need to protect Medicare from fiscal erosion. Although an important piece of legislation to the future of the federal role in the health system, it was largely overshadowed by a *Speech from the Throne* concerned with national unity and North American free trade (Debates, 13 May 1991, pp. 1-6).

C-20 was moved as a solution to the declining leverage of the federal government in health care primarily because it did not entail new or increased funding and, while the Department of Finance might have been unconcerned about the continued ability of the federal government to enforce the *Canada Health Act*, at Health and Welfare it was believed important to restore a stick to go along side the department's carrot (personal interview CDN 1). What C-20 demonstrates however, is the permeability of the federal decision making apparatus to issues or pressures moved from the outside environment - one of the preconditions of Therborn and Roebroek's irreversibility thesis. In addition, C-20 shows that despite provincial jurisidiction in health, the federal government possessed the necessary institutional tools to force provincial compliance to national legislation. In this instance C-20, like the *Canada Health Act* it was meant to strengthen, was passed in the face of some provincial opposition, particularly from Québec (La Presse, 28 February 1991). Thus, C-20 is an example of the Mulroney government's ability, or desire, to address policy concerns - although it might be argued by some that these were ill-timed, poorly considered and were, moreover, Band-Aid attempts at patching holes made by its earlier policies of fiscal restraint. It is therefore interesting to note in this regard that this new legislation safeguarding the *Canada Health Act* received only a one line mention in the Act's 1991 annual report (HWC, 1991, p.5).

8.1.1 Summary and observations

Both the manner in which the *Canada Health Act* was administered and the factors leading to the passage of C-20 highlight the lack of impact of New Right ideas in Canada and the moderation of the Mulroney government in addressing the area of health. As was noted previously, Canada's institutional structure would have permitted the federal government to completely withdraw its funding from Medicare and turn over the health system entirely to the provinces, this was in fact a proposal made by provinces at different times - an issue which I discuss below. Realistically this was never an option as the political risks of such a decision were far too high for any government to entertain. However, the federal government could have shown even greater leeway in permitting provinces to experiment with alternative forms of funding and delivery such as private clinics. Not only was this not the policy course taken, the Mulroney government further risked its relationship with the provinces by strengthening the *Canada Health Act* with the greater garnishment powers outlined in C-20. It is clear that the Mulroney government's need to act in defence of the principles of Medicare through the stipulations of Bill C-20 is a strong indication that the Government perceived a political risk in not strengthening this part of the Canadian welfare state. Moreover, the lobby efforts of a variety of activist groups such as HEAL further highlighted the political necessity of defending Medicare. Therefore, and to the surprise of many, a government which some had feared might be planning to destroy Medicare (personal interview CDN 2) was rising to protect it. Thus, just as Therborn and Roebroek (1986) theorize it is the consensus which surrounds certain parts of the welfare state which guarantee its irreversibility. But,

it is important to note that it is one thing for a government to pass a piece of legislation protecting the welfare state and it is another to actually act in its defence. In this instance, it is clear that while a financial sword of Damocles hung over certain provisions of the *Canada Health Act*, the main danger posed to Medicare during the 1984-1993 period related not only to dwindling transfers but also to the ministerial decisions to show some 'leeway' towards the provinces. In this sense, a stronger mechanism to strengthen the *Canada Health Act* might have been to make the penalty system less dependent upon ministers' opinions.

Institutional factors are also evident in this instance. As noted several times above the federal government was restrained in its ability to act in this policy field. In this instance, however, a new factor comes into play, that is the need to maintain federal-provincial harmony at a time of constitutional renewal. From Epp's original meeting with and letter to his provincial counterparts the necessity to seek collaboration with the provinces predominated. Thus, the constraint in the enforcement of the *Canada Health Act* can be said to have less to do with a proclivity against state-supported health care but rather to an inherently political problem endemic to the Canadian situation but none the less made more critical by the constitutional division of power.

While interest groups can be said to have played a largely secondary role in the Government's policy vis-à-vis the EPF, save for an apparent ability to forestall further restraint in 1992 and 1993, in the case of C-20 interest groups can be said to have been an important factor. However, what marks this activity is not the isolated lobbying of interests but rather their coming together in larger coalitions. One already existing since

before the 1984 election (the CHC), but said to have less influence on the Tory regime (personal interview CDN 1), and another (HEAL) whose insider strategy can be said to have borne fruit with C-20.

Finally, are we in the presence of New Right policies or do these mark a divergence from these. Unlike their British counterparts, the Canadian Tories did not come to power with social policy within their sights. Social policy for the Mulroney Tories was subservient to other more important issues such as expenditure restraint or federal-provincial accommodation. In short, neither the manner in which the *Canada Health Act* was enforced nor C-20 show evidence of a New Right policy agenda at work - in fact the contrary may be posited. In this instance Brian Mulroney's government highlights the very characteristics which have led some (Banting, 1992; Manga and Weller, 1991) to suggest that its variant of neoconservatism was of the non-radical, non-virulent nature.

In short, the Mulroney government in its continued defence of the *Canada Health Act* can be said to have been out of step with its neoconservative brethren . However, as I have discussed in the case of Britain, there too the rhetoric of Victorian social policy (see Richardson, 1993) was not matched by a radical rollback of the NHS but rather its continued existence and - in financial terms - expansion. Thus, the quasi-social democratic policies of the Mulroney Tories are not so aberrant in this comparative light.

8.2 Privatization

It was previously noted that one of the main themes in the overall policies of the Thatcher government concerned increasing the role of the private sector in the delivery of

what had been state services. This took a number of forms, denationalization and encouraging the take-up of private health and social insurance being the most common. Another strand of the same policy sought to engage the private sector in servicing the state apparatus. Measures to this effect included the contracting out of ancillary services as a means of improving the overall efficiency and effectiveness of the NHS. In Canada, while these policies were echoed at the federal level, in health privatization has come to refer to a complex set of policies ranging from user fees to the introduction of a US style private health care market. As such, privatization in the context of Canadian health policy bears little resemblance to similar discussions which occurred in Britain and is essentially a label affixed to anything felt to undermine Medicare. In short, privatization is not an end in itself but rather an umbrella term. Thus, for some user fees are one step towards privatization (see Gray, 1987) for others it is a synonym for the market. Thus, in Canadian terms both the use of prescription charges and the Internal Market would be defined as privatizations - although it is clear that neither of these in fact turned over the NHS to the private sector. The Mulroney government, because of its business-liberal idiom and its identification with the New Right and the Canadian business community, would see many of its health policies tagged as encouraging privatization. Thus, for example, many saw the cutbacks to the EPF as hastening the privatization of Medicare. The irony in such a statement being that because of the *Canada Health Act* the federal government could prevent provincial recourse to the private sector, but in and of itself the federal government did have the power to force provinces to privatize. It is in this sense that the issue of privatization is inextricably linked to the issue of the existence and

administration of the *Canada Health Act*. This is because among the five conditions of the *Canada Health Act* is the stipulation that provincial health systems must be publicly administered.[5] However, I remind the reader of Manga and Weller's argument that the Tories intrinsically favoured "demand solutions" to the problems of the costs of health care (1991, p. 214).

The great fear among those involved in the Canadian health system was that the progressive reduction in the cash transfers to the provinces, a process accelerated by the Mulroney government, would force the provinces to opt-out of the federal-provincial agreements underpinning Medicare. In other words, without federal money there would be no incentive to remain within the limits set out in the *Canada Health Act*. This is the very scenario which the federal government tried to address with C-20 although many continued to believe that the Mulroney government was engaged in a policy of privatization by stealth through restraint of the EPF (personal interviews CDN 2; CDN 8).

During its first mandate the issue of privatization would arise from two distinct exercises. The first was the *Ministerial Task Force on Program Review*, which I described above, and the second a report commissioned by the Government[6] and

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[5] To satisfy the conditions of the Act the criterion of public administration are, "(a) the health care insurance plan of a province must be administered and operated by a public authority on a non-profit basis by a public authority appointed or designated by the government of the provinces; (b) the public authority must be responsible to the provincial government for that administration and operation; and (c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with audit of the accounts of the province." However, under the Act the provinces were entitled to nominate an agency to "receive amounts payable on its behalf ... [or] carry out on its behalf any responsibility connected with the receipt or payment of accounts" (Canada, 1985a, Chapter 6, sections 8.1-8.2).

[6] A third report commissioned by the government (Canada, 1985b) consisted of a wide ranging literature review. This study was also cited by the Nielsen Task Force.

undertaken by Bud Sherman (1985), a Conservative and both a former Tory MP and Manitoba Minister of Health (Canadian Parliamentary Guide, 1982). What is interesting in this instance is the fact that Ottawa, which does not directly administer the health system, would devote resources to a study of private sector solutions to the continued affordability of health care. Clearly, the decision to undertake these studies and, secondly, the naming of Conservative Bud Sherman to single-handedly conduct one of these, could be thought to be a reflection of the New Right idiom in the first year of the Mulroney government. Of the two studies, not surprisingly, it was Sherman's which came out most strongly in support of private sector alternatives.

The Task Force's Report framed the problem of privatization by stating that the issue surrounding it was "establishing what role (kind and extent) privatization should play in the Canadian health system ... [and] what objectives should be achieved" (Nielsen, 1985, p. 31) and by listing the areas the where private sector could be more involved (Nielsen, 1985, pp. 31-32). In reviewing a number of studies of the issue the Task Force noted that there existed no significant support for privatization of the health system "from providers or consumers; but private sector involvement, in limited ways, was acceptable" (Nielsen, 1985, p. 32). Moreover, the Report concluded that the economic pressures had "led to a willingness to consider reasonable changes, which provides room for experiment in Canadian health care delivery techniques" (Nielsen, 1985, p. 33). Thus, noting that private hospitals were neither good nor bad for the overall public system, the Task Force stated that the real issue was one "of ideology as opposed to one of hard evidence on either side" (Nielsen, 1985, p. 33). But, since it is the provinces that administer and

operate the health system any move towards the privatization of this function would mean a withdrawal on the part of the federal government of its enforcement of section 8 of the *Canada Health Act* stipulating public administration of the system.

The Sherman Report, for its part, concluded that the "open-ended" nature of the Canadian health system "absolved" both consumers and providers of any responsibility for utilization of health resources. These recommendations could be interpreted as a call for the establishment of a price mechanism, such as user fees, as a means of controlling demand. However, the Report itself does not make an explicit call for such a measure (Sherman, 1985). The Report's recommendations called for:

1. Greater "federal-provincial exchange" regarding fiscal efficiencies in health care and the methods to achieve these;

2. Defining a role for the federal government in achieving greater efficiencies;

3. Changing federal legislation to encourage efficient practices (Sherman, 1985, p. 7).

The Sherman Report landed Jake Epp into another controversy when he stated before the Canadian Hospital Association annual meeting that the hospital sector should consider privatization as one way of resolving its financial problems - a conclusion which delegates present had difficulty accepting. Epp was quoted as stating that personal and professional experiences "ne devraient pas nous empêcher d'étudier de nouvelles avenues"[7] (Le Droit, 14 June 1985). In a 1986 interview Epp shifted from this position, "[...] I thought the Sherman report would put privatization to a large extent to bed. I think alot (sic) of people thought the opposite, that Epp was bringing forward the Bud Sherman

[7] Author's translation, "[these] should not prevent us from studying other avenues."

report because he was hoping that privatization would become the way of the future" (Ottawa Citizen, 20 February 1986).

The issue of privatization of the Canadian health system was not one long on the political agenda, with the possible exception of those concerned with the developments of private clinics in the Western provinces (personal interview CDN 8). As in the UK the issue of private sector provision soon began to focus on ancillary services rather than on the private provision of care. In this sense there was no question of either of these reports, particularly Sherman's, leading to the development of Canadian Harley Streets. While the issue of privatization would continue to be an active one on the provincial scene it was largely dead at the federal level. What these reports show rather is a contextual effect. As was noted in an interview, "In the health economics community consumer sovereignty was deliberated actively. Some of this spilled over into federal policy questioning and then it fizzled out. Privatization [of Canada's health system] was never on the political agenda" (personal interview CDN 5). This "policy questioning" was undoubtedly fed by the Government's New Right idiom.

In this instance three of our themes join together. Ideologically the desire to consider private sector options for health care delivery is undoubtedly a New Right issue. However, any policy which the federal government might arrive at was constitutionally limited. Moreover, a strong public consensus supporting federal legislation constrained the provinces' manoeuvring room. Moreover, this prevailing situation was one where each level of government constrained the activities of the other - irrespective of ideology - creating a stalemate that married the supportive consensus surrounding Medicare.

8.3 Health and the federal-provincial relationship

One of the factors which distinguishes the British and Canadian cases is the presence of a sub-national level of government which has constitutionally defined areas of jurisdiction and taxing ability to fund these. Throughout this study it has been noted that the Mulroney government's policies with regards to health were primarily driven by its fiscal problems leading to the restraint of EPF transfer. Coupled with the negotiations to renew Canada's Constitution the cuts to EPF forced upon the agenda an examination on the part of provincial and federal officials of Ottawa's role in health. The 1984-1993 period is therefore marked by simultaneous calls for the federal government to vacate entirely the health field - while providing the provinces with appropriate fiscal tools to fund the system - and other calls for increased funding and participation of the federal government to the planning of the future of Medicare. While my main theme of the influence of the New Right on public policy is not directly addressed below, this discussion will inform my institutional framework for comparison and my discussion of the factors which have prevented the rollback of Medicare. This discussion of federal disengagement will refer to calls for the federal government to vacate the field of health care or providing the provinces with greater leeway in the operation of their health systems. Leeway which put into question federal enforcement of the *Canada Health Act*.

The treatment of the issue of disengagement raises two questions: Firstly, was disengagement discussed as a policy option, to which the answer is yes. Secondly, did disengagement occur as a *de facto* result of the Government's primary focus on fiscal matters, to which I submit that this did in part occur.

In addressing the issue of disengagement it is important to stress the link between this policy, the calls for the federal government to vacate the field of health, and the constitutional discussions which occurred throughout this period. I have already noted that at the top of the Mulroney government's commitments was the amelioration of federal-provincial relations. Many policies were linked with this goal (see Toronto Star, 18 September 1984; also Debates, 5 November 1984, pp. 5-6; Doern and Tomlin, 1991, p. 227).

It is the Nielsen Task Force which first broached the possibility of federal disengagement from health. The Task Force observed that the *Canada Health Act* restricted the ability of the provinces to respond with flexibility to the pressures in their health system. As a result the Report recommended that the federal government should amend "or replace" the Act to introduce the needed flexibility (Nielsen, 1985, p. 14). In order to increase this flexibility the Task Force reviewed possible options which could form the basis of future federal policy. In particular the Task Force proposed an "evolution option" where the federal government would withdraw entirely from direct cash funding of the health system. In exchange the federal government would cede more tax room to the provinces to allow them to finance their health services (Nielsen, 1985, pp. 45, 46-47, 49-50). Such an option would have virtually eliminated the federal government's leverage in the enforcement of national standards (Nielsen, 1985, p. 14).

While the evolution option was not retained by the Mulroney government, it was none the less discussed among Canada's decision makers. In December 1990 a similar proposal was moved by Gil Rémilliard and Mel Couvelier, respectively the

inter-governmental affairs ministers of Québec and British Columbia, a proposal which was rejected by both health minister Beatty and by Bouchard who was then the senior political minister for Québec (Debates, 3 December 1990). However, it is important to place these proposals in the context of the wider constitutional discussions. In the first instance Québec's request for a federal withdrawal from health was part of the province's traditional demands for limiting the federal government's spending power (Milne, 1990, p. 324) and in the second a reflection of the radical New Right agenda of the Government of British Columbia whose aim it was to reduce the size of its social commitments - without federal interference (Marchak, 1990). However, the federal withdrawal option was not unanimously shared by all provincial governments (see Winnipeg Free Press, 24 April 1991).

As noted above, although the federal government did not withdraw from it attempts at enforcing national standards outlined in the *Canada Health Act* there remained the impression among many actors outside Ottawa that the federal government 'absented' itself - a *de facto* disengagement with institutional obstacles, primarily related to the constitutional aspect of the federal-provincial relationship in health, believed to be at the core of this situation. These institutional factors stood in the way of the Canadian government in a number of policy areas.[8] With regards to health the federal government in the 1980s found itself squeezed between the financial commitments made to the

[8] This can also be inferred by statements by Epp (see Toronto Star, 7 September 1984) and Bouchard (see Bouchard, 1991c) as well as the Government's statements of objectives as mentioned in the *Speech from the Throne* (see Debates, 5 November 1984). Finally the link between the constitutional question and the health file was noted in personal interviews CDN 1 and CDN 13.

provinces in the booming 1960s and the catastrophic fiscal squeeze of the late 1980s and early 1990s.[9]

This fiscal squeeze was coupled with the federal government's desire to break with the past, largely confrontational nature of federal-provincial relations. A strategy that also fit into the Mulroney government's obsession with securing a new constitutional accord and free trade agreements with the US and later Mexico. Therefore, while it was incumbent on the federal government to enforce the *Canada Health Act* it was apparent that at times the health minister would play down these issues in order to secure federal-provincial peace (personal interview CDN 1). Although the federal government does not directly operate Medicare it has over time developed a proto-steering capacity in provincial health policy development. Thus, an example of federal absence included[10] its withdrawal from participation in discussions concerning the future of Medicare, beit its funding or its operation. Federal-provincial meetings of ministers and deputy ministers set up to discuss issues of import to both levels of government often floudered when federal officials rejected these as venues for consultation and policy making. Thus, although the federal and provincial governments ofttten agreed that there was a need for concerted action, the federal government limited itself to acting as the "post office or clearing house for provincial policy" (personal interview CDN 16). Another description suggested that federal officials, Perrin Beatty particularly, were uninterested in any input

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[9] This aspect of the new fiscal relationship between both levels of government - due to the shift in economic circumstances - is noted by Butler (1993).

[10] The word 'absent' is the most frequently recurring description of the Mulroney government's participation in the health area over the period in question. In analyzing the interview material I have subsumed under the idea of absence issues such as lack of interest, as in interview CDN 2 with "absence of interest," or total disengagement from any policy activity beyond policing the non-discretionary sections of the *Canada Health Act*, as in interview CDN 16 with "the federal government absented itself."

from the provinces (personal interview CDN 2). However, the traditional role of the federal government is not one concerned with the micro-management of the health care system, that is the responsibility of the provinces. Rather, the federal government played up issues such as the principles and policy direction of the system. Thus, policy papers were the way that the federal government influenced health service policy. Both of these roles took shape in the federal government's involvement in funding the provincial health systems. It is the withdrawal from this 'macro' role which was to be the hallmark of the Mulroney government (personal interview CDN 2).

Where meetings were arranged to discuss the *Canada Health Act* a "don't rock the boat" attitude permeated federal policy, particularly in the post-1986 period where "the presence and the [enforcement of the Act] was light"[11] (personal interview CDN 15; also personal interviews CDN 4; CDN 10; CDN 11). Once again, the reason for this federal attitude stems from the constitutional situation (personal interviews CDN 1; CDN 2; CDN 3; CDN 9; CDN 11). This is an important point of divergence from the British case where constitutional matters played little role in the management of the NHS. In Canada the federal-provincial relationship was central to policy discussions since HIDS and much more so after the federal government armed itself with the *Canada Health Act* as the stick to force provincial cooperation and perhaps co-optation. Pledged to change a climate described as that of "[the]... Medicare battle between Ottawa and the provinces" (Toronto

[11] Interviewees familiar with the *Canada Health Act* noted that beyond the sections dealing with extra-charges and user fees, much of the Act and the federal government's role in its enforcement is discretionary. These sections included those mandating recognition of federal contributions and the requirement of provinces to inform the federal government about the administration of their health system. In addition, several regulations relating to the Act were not promulgated by the Mulroney government (personal interviews CDN 15; CDN 16).

Star, 7 September 1984), the Mulroney government found itself having to blunt the federal policy stick (the *Canada Health Act*). This was epitomized in Jake Epp's post-election statement on this issue: "I've always said federal-provincial relations and health care are best served in a co-operative manner - and that will be my agenda" (Toronto Star, 18 September 1984). This is somewhat of a paradox however as while tensions concerning the enforcement of the Act were dissipated, new tensions concerning funding of the system arose (Telegraph Journal, 7 February 1989; Le Devoir, 16 February 1989; La Presse, 29 November 1990; Globe and Mail, 17 June 1992).

In addition, it could be argued that the federal government could have taken on a greater leadership or steering role in provincial reform initiatives. However, this greater involvement was likely made impossible by other important agenda items such as constitutional renewal. Thus, with federal fiscal restraint already causing tension in intergovernmental relations the Mulroney government was unwilling to spoil the climate further through greater federal involvement in the administrative and structural issues pertaining to Medicare. It can therefore be said that where health, with the exception of its funding, might have been an area of federal-provincial conflict the Mulroney government steered well away.

In short, two elements arise out of the above discussion, firstly, that beyond its funding role the federal Tory government did not see for itself a very proactive role in the enforcement and maintenance of Medicare. In this regard C-20 was legislated well after the problems engendered by Wilson's EPF restraint policy had become obvious. This realization came seven years after the Nielsen Task Force had first pointed to the possible

reduction in federal influence as a result of federal transfer restraint (Nielsen, 1985). This may be explained by the institutional obstacles which stood in the way of active federal involvement - constitutional jurisdiction and the fact that the provincial level is closer to the provision end of health care than the federal government. Additionally, this desire on the part of the federal government not to get involved was probably a consequence of the larger political issues which dominated the period, that is constitutional reform and free trade. Raising a fight with the provinces might have been counterproductive to both exercises. However, it is not entirely correct to state that the federal government had 'no role,' as it had an important funding role in the system.

In this instance as well, as the previous discussion of privatization also highlighted, there was a willingness on the part of the Mulroney government to consider New Right solutions to its public policy commitments. However, these proposals never seemed to move past the level of study. In this case the Nielsen Task Force's "evolution option" would have altered considerably the state of Canada's health system. That such a policy was not pursued highlights the pre-eminence of pragmatic politics over ideological purity on the part of the Mulroney Tories. This was similarly the case with user fees and privatization.

8.4 Central agencies in the definition of policy

This and the following section will move away from a strict discussion of the Mulroney government's health policies to consider some of the other factors which were

at play in the 1984-1993 period. The first concerns where the decision making capacity with regard to health policy resided during the Mulroney years.

As can be expected from the preceding discussion, it is at the Department of Finance that the real decision making capacity of the Mulroney government on a variety of issues resided. This was apparent with the publication of *A New Direction for Canada* and the manner in which it defined the agenda and challenges of Canadian public policy in largely economic and fiscal terms. In large policy matters it is agreed that the battle for prominence within the federal government was won by Finance, and HWC simply did not carry the weight at the Cabinet table[12] (personal interviews CDN 1; CDN 9; CDN 13).

Kernaghan and Siegel (1991) describe the federal relations of power among departments as one which pits the so-called line departments against the central agencies. The former are largely service providers while the second have a primarily policy making mission. Although Health and Welfare had a policy role, this was not one which reached beyond its primary constituency. Finance on the other hand had a macro-policy capacity for it is there that the financial decisions central to all of the Government's missions were made. Officials at the federal health department were therefore at a disadvantage in relation to their counterparts in the central agencies. The power structure was in fact slightly more nuanced than such a simplistic model suggests. There was no equality of departments, but the interdepartmental power plays did not always end as one might have predicted. So it was that the Department of Finance had an agenda all its own, which line departments, such as Health and Welfare, tried to influence. This relationship

[12] One provincial official quoted officials from Health and Welfare as repeatedly saying "yes we'll pass your concerns along. [But] in truth, look Finance makes all the calls, we have no influence" (personal interview CDN 15).

between health and Finance had not always been so lopsided. Before the creation of the EPF Health and Welfare had a stronger policy role, although it was limited to filling the cheques for half the cost of decisions made at the provincial level. The creation of the EPF in 1977 instituted a primarily financially driven policy that was now in the hands of the Department of Finance. Thus, not only did power over health care effectively flow to the provinces in 1977 (as they were no longer tied to conditional grants for health) it also meant that influence over health policy would now be primarily regarded as financial and thus decision making moved from Health and Welfare to Finance.

Another one of the problems faced by Health and Welfare was that it was often seen as a largely junior ministry by its provincial and federal counterparts. While provincial health departments are senior ministries due to the very size of their budgets, the federal department does not share the same clout at the federal cabinet table (personal interviews CDN 1; CDN 14). Thus it was incumbent on the holders of the federal portfolio to bring clout to their department in meetings with provincial counterparts or even within the federal government. Therefore, with the withdrawal of federal money, the federal government's fairly weak position on the health file was further weakened and, as a result, the federal government had sunk to the bottom of the ladder of health policy stakeholders (personal interview CDN 14).

But why was Finance pre-eminent? The answer to this question stems largely from the size of Canada's perceived fiscal problems and the Government's willingness to act in this area. In short, the world-view of the officials at Finance matched that of the Minister of Finance, Michael Wilson, and to a degree his successor. From the

Department of Finance's point of view, the hallmark of health policy during the period of the Mulroney government was the need to restrain expenditures. "You don't need to restrain expenditures unless a programme is growing by leaps and bounds" (personal interview CDN 13).

The solution was therefore on the table even before the Mulroney Tories entered office, an episode chronicled by Bercuson et al. (1987). As far as the Department of Finance was concerned, it was impossible for the federal government to deal with its financial and fiscal problems without cutting off the provinces. While it can be argued that the Mulroney government did have only limited room to manoeuvre as a consequence of the mounting national debt and consequently spiralling deficit, it did have ultimate decision power over what areas were cut or restrained and which were not. As was noted,

> [So] the government sets it's priorities and determines how it wishes to deal with individual sectors to which it spends, directly or indirectly, and the EPF funding was restrained. Growth was restrained then frozen. [The federal government's stake in the country's social system and fabric therefore became] a matter of what place transfers occupy [in overall government priorities] (personal interview CDN 13).

In the end the issue becomes one of which federal department, or which group or individuals, were running the health portfolio. While the provinces constitutionally administer the health system, the large budgetary impact of federal transfer payments moved much of the decision making regarding health to the Department of Finance. In short, the department had become the *de facto* health department on matters regarding funding of the system (personal interview CDN 13).

The pre-eminence of Finance to the direction of Canadian health policy adds a new element to this institutionalist discussion. In this instance it is clear that the veto power over particular policies resided with Finance. Therefore rather than having an institutional obstacle defined by the Constitution, Health and Welfare was blocked by the administrative structure of the Canadian government. By contrast, as Lawson's (1992) account of the Treasury's battle against tax relief to encourage the take up of private health insurance shows, in Canada the counsel of the Department of Finance managed to sway politicians to its overall fiscally conservative agenda while in Britain the Treasury's agenda was made to bend to the will of politicians.[13]

Also, the pre-eminence of the Department of Finance on the Government's macro-policies raises the theme of New Right politics. It appears from the material presented above that the Department of Finance had well defined fiscal objectives which appeared independent or unrelated to the government's ideology. Bercuson et al. (1986, p. 90) write that much of the policy of fiscal restraint existed on paper before the 1984 election and would likely have been implemented had the Liberals been returned to government. I described above the manner in which neoconservatism influenced the policies of the Liberal government. In this instance I suggest that the Department of Finance was responding to an economic paradigm that was common across the West and that had begun influencing Canadian policies in the late 1970s. However, these policies matched more closely the Mulroney government's main philosophical leanings and these began to influence wider policies than might have been possible under the Liberals.

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[13] A similarly independent role was played by the Bank of Canada in the battle against inflation, particularly after 1990 (see MacQuaig, 1995).

Therefore, in so far as it is possible to divine the motivations of individuals from research interviews and documents, it appears that the pressure to restrain federal social spending came primarily from within the bureaucracy. This met with Michael Wilson's business liberal outlook on matters of social policy (personal interview CDN 1) to create the government's EPF restraint policies. However, it is clear that Wilson's energetic attack on the deficit was not shared his all his colleagues and Mulroney in particular (see Bercuson et al., 1987, pp. 88-92) pointing to a moderate strain in Canadian Conservatism between 1984 and 1993. A moderation likely explained by the meeting of traditional Tory ideology (Red Toryism) and political imperatives based in the need secure power. Therefore, because the case for fiscal conservatism was primarily championned in intellectual and policy terms from within the bureaucracy, it lacked the strength and influence which its articulation at the political level would have afforded. Because the senior civil servants at the Department of Finance were one-step removed from the ultimate decision maker their articulation of New Right policy options was intrinsically weaker that would have been similar efforts done from within the political sphere of the Government. In contrast, in Britain the case of New Right alternatives was made by the political class which in turn set the tone and direction for the policy environment in which the bureaucracy operated. Furthermore, because the Mulroney government was itself divided along business liberal and Red Tory lines it became much harder for the officers at Finance to move their policy alternatives. As a result, the bureaucracy's endorsement of neoconservatism was further diluted when it came to the development of policy alternatives. Thus, with the exception of a few neoconservative Cabinet ministers, such

as Michael Wilson, the ultimate decision making of the Mulroney government showed moderation rather than radical ideological drives and pragmatism rather than politics imbued by conviction.

In terms of my overall comparison, it is clear that the leadership role played by the Department of Finance distinguishes the Canadian from the British case. In addition, it shows the Canadian variant of the New Right to be somewhat more amenable to pragmatic politics rather than ideological purity. In short, especially when considering the Trudeau government's latter fiscal policies, the policies concerning EPF restraint appear not so much New Right as the consequence of a general economic and fiscal malaise in the Canadian situation which was treated - as in many other nations - with a remedy of fiscal restraint.

8.5 Interest group coalitions and federal health policy

In my discussion of the British policy environment I examined the nature of the relationship which existed between the Thatcher government and health interest groups. It was noted in my discussion of the British case that interest group politics in terms of health primarily involved groups, either professional associations, interest groups or trade unions, that acted individually in their relations with the Thatcher Government. Although some of these groups agreed on a number of issues - for example with regards to the Internal Market - redistributive tensions kept them apart. As a result the Thatcher Government was able to more easily exclude groups from the policy development process - in some cases running roughshod over their opposition to certain policies. In Canada

the situation in the early years of the Mulroney Government was quite similar. The issues treated below are: Firstly, which NGOs were active during the period in question; secondly, what was the nature of their relationship with government; and finally, what successes or failures did they score and why.

The Canadian interest groups include a variety of groups ranging from interest coalitions to professional associations and, all of them at one time or other, participated in the policy process, or "official legislation" process (Finer 1966), although how successful they were is a matter of some debate. However, rather than map the 'policy community' this section will look at a particularly Canadian phenomena in health politics, that is the emergence of interest group coalitions. Two groups stand out, HEAL and the CHC.

The Canadian Health Coalition (CHC) was formed in the late 1970s under the leadership of the Canadian Labour Congress.[14] The Coalition included representatives of churches, trade unions, women and patient groups, hospital employee associations, the Canadian Council on Social Development and the Canadian Federation of Nurses Unions. The Coalition's mission statement was to save Medicare and improve the health system and in this was especially vocal in its opposition to any attempt to privatize the health system, at times finding support from the Liberals and NDP at both the federal and provincial level. By 1985 the Coalition had over two million members (Gray, 1987, p. 21).

As an coalition the CHC represented a wide swat of interests, although this did not translate into concrete influence or access to the Mulroney government. As one CHC

[14] The Canadian Health Coalition is primarily made up of public sector unions, but as such this division of activity should also be seen in the case of CHC affiliates. Thus, unions acting independent in the pursuit of parochial interests and under the CHC umbrella for larger system wide policy.

official described the period, "[we had] no communication at all" (personal interview CDN 10). As a result the Coalition concentrated its efforts on external activities such as demonstrations on Parliament Hill in Ottawa or shadowing the Minister of Health and Welfare (personal interview CDN 10). But it is these very tactics which may have undermined its ability to gain access to policy makers (personal interview CDN 1). In addition to its choice of tactics the CHC's lack of success also had much to do with its clear identification with the Canadian Left. Primarily led and financed by the Canadian Labour Congress - which has an open electoral alliance with the NDP not unlike that between the British TUC and the Labour Party - it tried little to find a point of accommodation with the Tory government, and by the same token the Government did not feel inclined to bring the CHC into the consultation loop. As such, the lack of success and access of the CHC is primarily the result of a mutual inability to bridge the Left-Right political divide. While the CHC represented the wider health care interests in Canadian society, the professional groupings concentrated on a less obvious strategy more closely akin to Finer's lobby.

The Canadian Nurses Association was one of the driving forces behind the formation of the Health Action Lobby (HEAL). Formed in 1991, HEAL is a coalition of seven national health and consumer organizations and 20 affiliate organizations.[15] In its statement of purpose HEAL states that it is "committed to working with other organizations, the private sector and governments to develop practical approaches to the

[15] The membership of HEAL includes: The National Federation of Nurses Unions, The Canadian Medical Association, The Canadian Consumers Association, The Canadian Hospital Association, The Canadian Long Term Care Association, The Canadian Psychological Association and the Canadian Public Health Association and another twenty affiliate organizations.

problems confronting health care" (HEAL, 1994). Thus, contrary to the CHC, HEAL adopted a non-partisan and non-confrontational approach to its relations with the Conservative government. It wanted to work with the Government - and gain access to the decision process - rather than protest from the outside as the CHC was doing. Prompting the formation of HEAL was the realization that the Mulroney government was not inclined to listen to any one interest group. In short, the member associations decided that while it might have been possible to ignore separate professional groups acting in their own self-interest and from their own agenda, it would be more difficult for the Mulroney government to ignore all of the major professional groupings working from a common agenda and with a common purpose. In other words HEAL was a joint lobbying effort (personal interviews CDN 4, CDN 11). Operationally the professional associations that were members of HEAL continued to lobby for their parochial interests individually but went through HEAL for issues of system wide policy, for example with regards to EPF restraint (personal interview CDN 11; Tholl and Sanmartin, 1993).

But HEAL was also a reaction to the inability of the health interest community to either have access or make significant impacts on federal policy. Reflecting on the 1991 cutbacks, it was noted that ,

> What we learned by 1991, when we looked at all the cutbacks that had occurred, [we saw that] this association [CNA] [had] responded to the cutbacks that had occurred [by ...] doing our own thing. So we pulled together a small group and looked at what we could have accomplished if we had worked together. When you put an organization like HEAL together, governments listen (personal interview CDN 11).

One of the accomplishments claimed by HEAL was the stalling of further cuts to the EPF transfers and ensuring that the *Canada Health Act* would continue to be effective through to the passage of C-20 (personal interviews CDN 11; CDN 4; CDN 1; CDN 9).

HEAL's success was partly the result its low-key non-confrontational approach to federal policy makers and the fact that it was felt to share the same overall view of the health system and policy as the federal government (personal interview CDN 1). Thus, HEAL's message to the federal government regarding funding was that it was "[impossible to] play in the policy arena totally if you have nothing on the table to offer. That's not usually the way any kind of policy direction or policy gets created or leadership emerges" (personal interview CDN 11). Moreover, HEAL identified the need to keep the link between the federal contribution and the health care system: "The [...] initiatives [...] have to be broad enough to be seen to be health care by the Canadian people. Because they are not going to see disease control, but [Canadians] identify with their Medicare card" (personal interview CDN 11).

HEAL's advocacy brought it in contact not only with the political class, but also with senior bureaucrats and these contacts led to some of HEAL's successes. For example, officials at the Department of Finance became more accessible once HEAL had established its credibility. To do so HEAL, unlike the CHC, decided to adopt the same language as the Department of Finance and it too began focusing on economic and fiscal issues. Through this its representatives were able to show their credibility by producing evidence of the link between the Government's fiscal restraint policy and its impact on health policy. There was, in short, a change from a reactive advocacy approach to one

based upon constructive engagement and shared knowledge and principles (personal interview CDN 11).

Additionally, unlike the more politicized CHC, HEAL did not engage in political activity, demonstrations or the courting of opposition politicians. This lack of political advocacy may be a reflection of HEAL's membership which usually sought to float above the political. Moreover, HEAL's membership included among the most conservative of professions such as medicine and health administration. What tensions did exist were largely confined to those within the member organizations. For example between the provincial constituents and the federal office of member associations. These divisions were also exacerbated by the development in Québec of professional bodies independent from - although associated to - the federal organizations (personal interviews, CDN 4).

Outside of HEAL the individual associations continued their advocacy through traditional means such as participation in the Government's pre-budget consultation process through briefs to the Minister of Finance, as well as commenting post-budget, and in hearings, before House of Commons and Senate committees. Through these activities HEAL and individual associations would continue to make their own representations to the Government regarding the impact of the budget and further budget cuts on the health care system. Moreover, this type of activity - open and transparent advocacy - permited the organizations to reach past parliamentarians and address public opinion as well.

As a relatively new organization it is difficult to determine HEAL's true effectiveness. As one official described, "HEAL is important as a reflection of

producer-consumer cooperation, but its effectiveness is yet to be worked out" (personal interview CDN 5). As for the CHC, its constituency was not one primarily sympathetic to or influential with the Tory government and their ability to affect policy was quite minimal. However, by adopting the role of watch dog to Medicare it played an important role in keeping any potential rollbacks - or perceived rollbacks - well in view of the public. HEAL, for its part, did not crave a similar public role.

Another particularity of the Canadian case is the role which business groups were believed to have played in the development of the Mulroney government's social policies. As one interviewee noted, "... the Canadian Chamber of Commerce and the Business Council on National Issues (BCNI) has a much closer relationship with the Minister of Finance than the health organizations might ever hope to achieve" (personal interview CDN 4). In the case of Britain, while interests on the Right were believed to have had some influence in the policies of the Thatcher government (see Cockett, 1995), in the case of Canada similar influence from the right came primarily from business groups such as the CCC and the BCNI (see McQuaig, 1991; McQuaig, 1995). However, this influence remained largely at the level of the micro-policies of the government and only the BCNI attempted to posit social policy alternatives - policies which they argued would improve Canada's competitiveness (personal interview CDN 6). However, by influencing the Government's fiscal policies these groups also had influence on the shape of federal social policy - including Medicare (personal interviews CDN 2; CDN 4; CDN 11). While some within these groups will deny any overt (or covert) influence on the public policy process (personal interview CDN 6) their success in influencing policy was

noted by several respondents (personal interview CDN 1; CDN 9; CDN 13) who stated that the business community did, in fact, have some influence - although this is nuanced with a claim that in the end it is government and not business that makes policy. It was further noted that the policy process "is not an egalitarian one" and that not all groups received an equal hearing by decision makers (personal interview CDN 5) suggesting that groups, such as the BCNI, might have gained access to policy makers to the detriment of other groups.

Interestingly, one of the contrasts between the 'anonymous empire' of business-government relations is that of the level of contact between the federal ministers and the non-governmental sector. If HEAL was successful after its creation in gaining access, for most of the period the traditional health community was shut out of the link with the Government. The experience of groups such as the CMA and the CHA is, in this regard, quite similar to that faced by the CHC. For example, the CMA was never invited to meet with Jake Epp and meetings with officials were no more encouraging (personal interview CDN 16). This experience was common elsewhere (personal interview CDN 4). The access of the CMA to the Government improved in the latter part of the Tory mandate, no doubt due to the commitment of Minister Bouchard and a change in the way the CMA looked at issues, for it was also noted that unlike his predecessors, stakeholder meetings with Minister Bouchard did make a difference in terms of Government policy (personal interview CDN 14).

In closing, in terms of my contrast between Canadian and British health policy, it appears that Canadian interest groups had marginally more success at influencing health

policy than did similar interest groups in Britain. This can be explained firstly by the relative moderation of Canadian Conservatism with regards to matters of social policy. Thus, due to overarching political and jurisdictional imperatives the Mulroney Conservatives were not intent on a New Right revolution. By contrast, the more radical agenda of the Thatcher government required it to minimize the influence of interest groups as a means of neutering opposition to its successive - and wide ranging - policy drives. That being said, Canadian interest groups, particularly provider groups, were largely shut out of federal policy making until late in the Government's second mandate and only then once they grouped into a coalition. Therefore, while several may be tempted to trumpet HEAL as the main actor forestalling further EPF restraint, a contrary explanation may be that by its 1991 budget, with the nation in recession, an election looming, and a constitutional agreement still to ratify, the Mulroney government had lost its appetite for further cuts. The Cabinet shuffle moving Michael Wilson out of Finance seemingly ended the Government's era of restraint. This conclusion supporting my thesis that interest groups in Canada were peripheral to health policy development - although they had more influence in Canada than in Britain.

8.6 Conclusions to the Canadian case

As I discussed above, the period of the Mulroney government was primarily marked by an agenda focused on economic and fiscal renewal. As such, health played a role in the overall policies of the Government only in so far as social programmes

contributed to the Government's budget woes. Moreover, the area of health is one where the state of federal-provincial relations was an important factor in determining Government policy. It is important to recall here that the *Canada Health Act* was only months old when the Tories came to power and the passage of the Act was played out in the theatre of federal-provincial acrimony.

Based upon the material considered it appears that the federal government did not have an active policy aimed at any particular reform of the health system. This is not to say that the federal government was unaware that its policy of reducing the size of its transfers to the provinces would have a serious and largely negative impact on public finances at the provincial level. In this light it is paradoxical that the federal government was actively engaged in budgetary measures that passed on to provincial governments the problems that it was trying to forestall with its own budget, namely a ballooning debt and deficit. However, although contradictory in scope this is the policy course pursued over the nearly ten years of the Mulroney government.

Few governments can manage to hold a definite policy course over years in office and in this regard the Mulroney government was no different. Thus while it moved to resolve its fiscal problems, it further boxed itself into a contributory role in Medicare with C-20 and its insistence on maintaining the *Canada Health Act*, all the while being lax in its enforcement of its dispositions. Moreover, although the restraint policies of the Mulroney government prompted provincial reviews of their health systems, it is also true that several of them were already engaged in reforms of their health systems well before the election of the Mulroney team. Québec, for example, had begun to study the reform

of its health system well before the election of Brian Mulroney's Tories (Deber et al., 1994; Québec, 1990). This is not to say that the federal government was uninterested in the shape of provincial health systems, but simply that pushing reform was not part of the federal agenda - nor was it within its jurisdictional ambit to do so.

One interesting aspect of the Mulroney policies is that they permitted the federal government to engage in politics of blame-avoidance (Weaver, 1986). Acting as it did it forced the odious decisions in Medicare onto the provinces. Thus, as was noted, "Nobody blames the fads for closed beds" (personal interview CDN 16): true but only because in the end it is the provincial and not the federal government which ultimately decides how the money is spent. However, the federal government was not able to entirely cast off blame for the outcome of its decisions as its recourse to the politics of pragmatism in passing C-20 and in stalling a further round of EPF restraint testify.

In short, it is my view that the federal government did not have a specific agenda in the health care field. Rather its policy decisions were determined largely by economic and fiscal considerations. Moreover, while some point to cuts in the EPF as a sign of federal willingness to sacrifice Medicare, we must also recall that the EPF also covers post-secondary education and it may be the switch from cost-sharing to block funding in 1977 which had the most impact on the financing of Medicare rather than any cuts which occurred post-1984. Thus, the evidence that the Mulroney government targeted health care is somewhat weakened. In the end, the Mulroney Tories took decisions relating to its fiscal position. Other sectors were cut, not just health.

While not directly involved in the provision of health services the federal government has had a historically significant role in shaping Canada's health system. Perhaps, rather than leaving health to weak and uninterested ministers, Mulroney could have given health a higher cabinet profile and, as a result, a higher national profile. It is almost certain that many of the policies and options now being considered both by the federal and provincial governments would have benefited from the centralizing role of the federal government. But social policy in general and health in particular was not a Mulroney priority and his willingness to let the provinces sort it out for themselves may have much to do with his obsession with constitutional renewal, particularly during the Government's second term (personal interview CDN 1).

So the paradox of Conservative health policy between 1984 and 1993 remains, that is, that the policies which were to have the greatest impact on Canada's health system were made not at the table of health ministers, groups or bureaucrats but rather over in the Department of Finance. Thus, as noted above, Mulroney's health policies reflected the prevailing neoconservative economic paradigm - in Canada and elsewhere. The Mulroney cuts were not ideological - he did not take the proverbial axe to federal spending - but carefully targeted to areas where the Government would face the smallest political difficulties. Although, as occurred with OAS deindexing, the Government occasionally miscalculated.

In terms of the themes of this research the following conclusions can be made. Firstly, as I have noted above, Canada's division of power limited the manoeuvring room of the Mulroney government on a number of fronts relating to health care. However

where it did have a policy tool at its disposal - the EPF - the Tory government was an active and effective agent of change. Over its almost ten years in office the Mulroney government managed to alter significantly the shape and size of federal contributions to health. However, it remains that it is most likely that these compressions were the result of an economic/fiscal agenda prompted by its membership in the New Right club and less by a desire to change the values of individuals or the social role of the state. On the whole, however, as Banting (1992) has noted the Mulroney Tories were rather moderate as compared to their British peers. This moderation speaks to the continued presence of the traditional Tory strain in the policies and politics of the Conservative Party under Mulroney. Although much more business-liberal that his predecessor Clark, Mulroney's policy stance reflected that of the majority of the party's membership in the 1980s (Perlin, 1985). But, the particular regard given to Medicare - among other social policies - by Mulroney showed him to be politically pragmatic but also influenced by the Conservatism of previous leaders such as Diefenbaker (for whom Mulroney worked) (Grafftey, 1987), a Toryism akin to that of "Shaftesbury and Disraeli" and conservatism that tried to be economically and socially conservative, yet also progressive in matters of social needs and economic management (Campbell and Christian, 1996, pp. 40, 44). Further sources of this moderation on the part of the Mulroney Conservatives - especially in comparison to their British counterparts - included the brokerage nature of Canadian party politics, the limited number of institutional tools in the hands of Ottawa to reform Medicare beyond its financial basis, the persistence of interest groups to engage the

Government, social policy's role as an instrument of national unity and, perhaps more importantly, the high levels of public support for Medicare.

The thesis of welfare state irreversibility is sustained by my examination of the Canadian case. In this as in the British case, inherited policies supported by public opinion continued to determine Medicare policy. This can be seen in several ministerial pronouncements and, most explicitly, in the Government's decision to introduce and pass C-20. As an organization primarily interested in gaining and keeping power there were simply too many risks for the Conservative Party in a rollback of Medicare.

Interest group politics was a factor during the 1984-1993 period although the overall effectiveness of these actors was fairly minimal. The most interesting feature of this aspect of the study was the development of interest group coalitions - a feature not present in the British situation.

Finally, did the Mulroney government use incrementalist policies? Unlike the British case it is possible to reply in the affirmative. The budgetary policy of EPF restraint is an almost textbook example of budgetary incrementalism as described by Wildavsky (1964) and others. On the wider spectrum of health policy, as the federal government was the junior partner its policies were, perforce, incremental in nature.

In the next chapter these conclusions and those concerning the British case are drawn together and compared.

PART IV, CHAPTER NINE:

CONCLUSION

9.0 Introductory comments

The preceding pages considered the politics of health in Canada and Britain under Conservative government. This study finds its particular relevance in its examination of the policies and politics of the New Right framed, as they were, within the larger politics of the 1980s global economic crisis (Gourevitch, 1988; Kreiger, 1989). This crisis had an intellectual spin off which animated the politics of the New Right in Canada and Britain. How deeply this affected policy is the question underlying this study.

As noted the crisis differed perceptually in Canada and Britain. In Canada, the crisis of the 1970s and 1980s was largely a psychological one and even into the late 1980s Canadians continued to think of their economy as growing and the role of government as needing to expand. In Britain the crisis was more deeply felt due to a tangible decline in Britain's industrial sector. Coupled with the recourse to the IMF and industrial relations fraught with acrimony and stagflation, commentators spoke openly of a British disease. The so-called 'Winter of discontent' seemed to encapsulate the decline of Britain's economic capacity.[1] If Canada and Britain ended up with political parties which espoused broadly similar political objectives, although these parties differed in how they defined the problems of their countries and in their rhetoric, the reason may lie in the commonality of the pressures or challenges posed to them as a result of the economic crisis.

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[1] The Conservative Manifestos in 1979 and 1982 state clearly the need to reverse/ stop this decline.

The central focus of this study is the macro politics of the New Right and how it found effect in the micro-policies of governments, with a specific emphasis on the macro and the micro politics of health care. To do so this concluding section will consider in turn the four main themes of this research and in so doing will advance four main assertions: Firstly, although no radical rollback of publicly funded health care is evident, both systems did none the less experience policy shifts - shifts which were far more wide ranging in the case of Britain than Canada. In short, the ideology of the New Right, as practised by Mulroney and Thatcher, made a significant impression on each health system - although more so in Britain than in Canada. Secondly, the main factor explaining this different outcome can be ascribed in terms of the institutional distinctiveness of each country, a factor which goes beyond simply the nature of the state but includes other institutional factors such as their constitutions, legislations and the organization of actors in the health system. The differences in the scope of the policies pursued by the British and Canadian governments relate directly to their different relationship to the health sector. In the Canadian case, the federal government's involvement in health and welfare comes mostly from its financial contribution to provincial health plans. Ottawa did exercise moral suasion and legislative powers regarding how these programmes were administered, but, as its financial stake was reduced between 1984 and 1993 so was its steering capacity. Overall the Canadian government's involvement is financial; provision of services is a provincial responsibility. In the British case, the Government is involved in all three aspects of health policy: It funds the health system directly, sets its overall policies and assumes the majority of health provision. This gives the British government greater steering capacity than the Canadian government. An unexpected finding of this research, however, was that despite

having fewer institutional tools at its disposal the Mulroney government was much more effective at curtailing the increase in health funding than its British counterpart. Thirdly, another main point of divergence lies in the nature of the policy making process in Canada and Britain. It was found that the model of incremental policy making proposed by Lindblom (1979) and Wildavsky (1964) and others is useful in examining Canadian developments but less so in explaining the major policy departures found in British health policy. Fourthly, that the participation of interest groups to the development of health politics was not found to be a determining factor in the policies which were initiated by the Canadian and British governments. On this theme this study found a divergence between the pattern of interest group activity in both countries with Canadian groups seeking to form common fronts while British groups continued to work in isolation from one another. On the whole, however, interest groups were found to be peripheral to the politics of health during this period.

While I focus on these four main assertions, none of these themes should be seen as exclusive and a fair amount of overlap exists among them. Further, I do not wish to leave the reader with the impression that I consider these themes and concluding statements to be all-inclusive. As I will discuss below, this is but one small part of a very large area of study and I make no claim to have covered all the myriad thematic and political research avenues. In fact, as I will posit below, it may be that the field of health care is particularly susceptible to explanations that are multi-factoral. In short, rather than seeking a single framework to explain all the developments which occurred in health policy in Canada and Britain between 1979 and 1993 each framework explains a small part of a larger public policy mosaic.

9.1 The New Right and health policy

As the title of this research suggests my main concern has been to establish the impact of conservative government on health policy. To do so I have tried to narrow down the ideology of the New Right variant of conservatism to a number of key ideological policy proposals or ideological markers. Drawing from a number of writers identified above I have chosen to concentrate this analysis on three main tenets in the political programme of the New Right, these are: Private rather than state provision of social services; needs based targeting of social provision; and an intention to control public expenditure. As Linder and Peters (1989) note, the choice of policy instrument is consequential on the perceptions and subjective values of the policy maker. As such, the distinctive approach to public policy shown by governments of the New Right can be said to be based upon the way in which the New Right defined a set of values and perceptions distinctive from the those associated with the social democrative Left or the KWS. As the number of policy tools at the disposal of governments are limited (Linder and Peters, 1989, p. 35), the choices made by the Thatcher and Mulroney governments must be seen within a larger whole rather than simply circumstantial selections and decisions - selections which were conditioned by a distinctive set of New Right values. In the case of Canada, however, many of the choices which were to be made by the Mulroney government were conditioned by institutional tools inherited from the previous Liberal government. Moreover, the neoconservative expenditure restraint measures initiated by the Liberal party before 1984 also entailed institutional reforms. Thus, in managing the economic difficulties of the 1970s and 1980s the Trudeau Liberals redefined the system of transfer payments for health through the creation of the EPF, thereby creating the main policy tool utilized by Michael Wilson between 1984 and 1991 to reduce federal

expenditure. Had the EPF not existed in 1984 the Mulroney government would have been tied to paying a 50 per cent share of provincial expenditures for health, hampering or delaying its fiscal strategy. The fact that such a major retrenchment of the federal role in funding Medicare occurred under the Liberals partly explains the moderation exhibited by the Mulroney government. Simply put, the Liberals had instituted in 1977 a sufficiently large cut in federal contributions as to delay further drastic action on the part of its successor. Although the Mulroney government reduced significantly the growth of federal contributions, it did not, as had it predecessor, redraw both the method by which funds were transferred to the provinces and the amount of these transfers.[2] Paradoxically, while it is the Liberals that first attempted to disengage Ottawa from funding health, they were also the Government responsible for the *Canada Health Act*. The Act, as I noted above, created the main obstacle to federal encouragement of the types of reforms which marked Britain between 1979 and 1990. That the then opposition Conservatives voted with the Government to pass the Act, thereby limiting its future room to manoeuvre on health policies, testifies to the political necessity for Canadian political parties to support Medicare as a programme and institution. Thus, although it is the policies of the Mulroney Tories which have been the focus of this research, the policies they pursued found shape within the institutional context and framework defined by their predecessors.

The control of expenditure is one area of public policy on which both the Canadian and British streams of 1990s Conservatism agreed, and the discourse

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[2] It is interesting to note here that in its 1995 budget the Liberal government of Jean Chretien did away with the EPF entirely and created a new funding regime, the *Canadian Health and Social Transfer* (CHST). This new transfer, which came into force in 1996, combines funding previously assumed under the EPF and CAP. In addition the CHST also further reduced federal social transfer funds (see Courchene, 1995).

concerning the general economic management which emanated from both governments was remarkably similar. For example, many of the same themes are raised in *A New Direction for Canada* (Finance Canada, 1984) and *The Next Ten Years* (Treasury, 1984a). In general economic terms both government's were determined to restrain state spending, privatize state enterprises, adjust taxation levels, and control inflation (Bercuson et al., 1987; Finance Canada, 1984; Conservative Party, 1979; Conservative Party, 1983; Conservative Party, 1987; Mishra, 1990). All of these goals were consistent with the economic philosophies of the American New Right, exemplified mostly in Friedman and the Chicago School, and were pursued as a means of encouraging the private enterprise sector (Green, 1987, see especially pages 55-91). In the area of general social policy these economically liberal policies had the effect of initiating curbs in the growth of programme spending, where practicable, and generally push governments to seek to restrain social expenditures. In both Canada and Britain this restraint drive also entailed a move towards making the machinery of government and its regulations as efficient and effective as possible (Simeon, 1993).

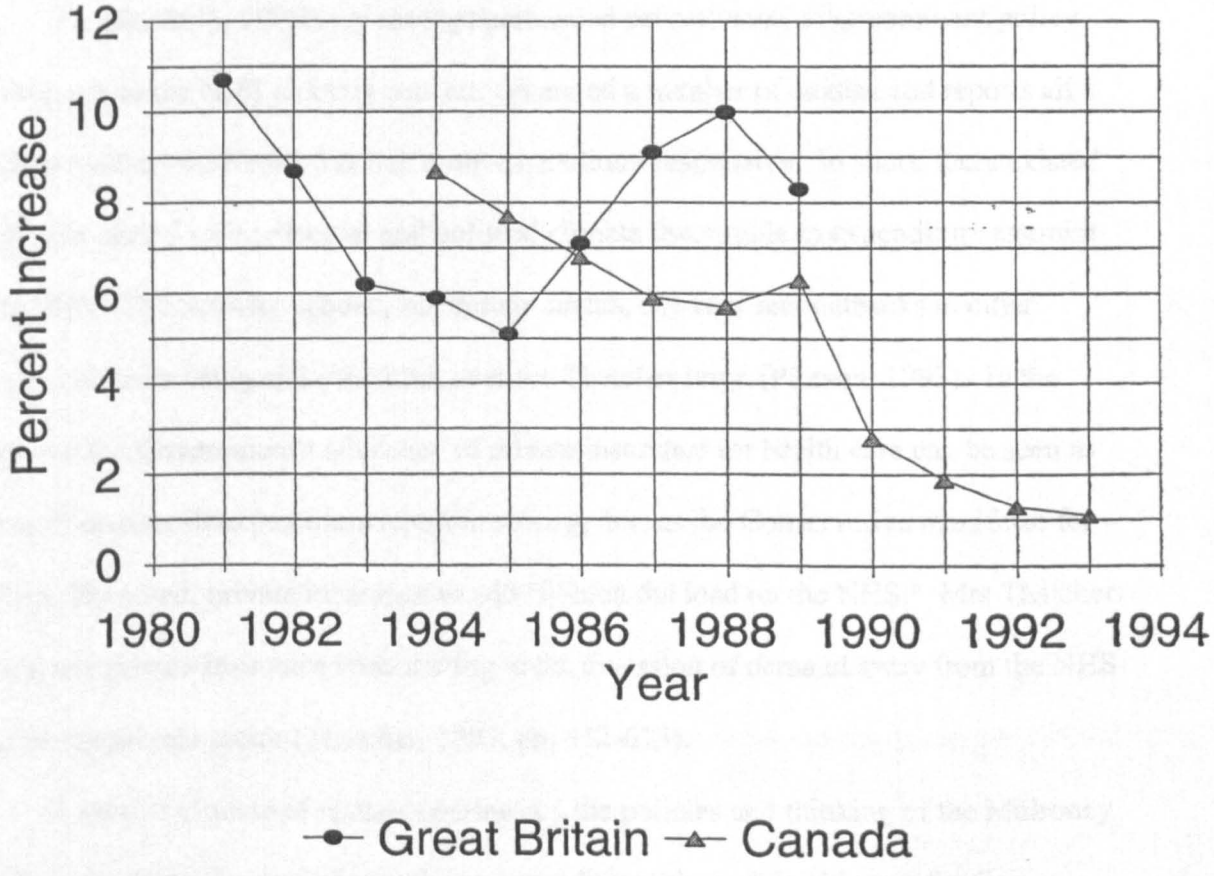
Although both the Mulroney and Thatcher government's were committed to expenditure restraint it was found that when it came to the funding of health care a wide divergence existed between both countries. While it is my contention here that the Canadian state had less policy tools at its disposal than the British, this is not to imply weakness on the part of Canadian policy makers. As Figure 9.1 below shows, the Mulroney Conservatives cut the rate of growth in health funding significantly as compared to Britain. Taking the figures for England only, between 1980 and 1984 the Thatcher government had successfully paired down the rate of increase in health spending from a whopping 23.3% in 1980 to slightly under six percent in 1984, after which annual

rates of increase edged back up to over eight percent between 1987 and 1990. However, while Michael Wilson's changes to the EPF formula were incremental in nature they were no less significant in curbing the annual rate of increase - with the most dramatic drop following the 1990 freeze on EPF payments. Figures presented in Chapters Seven and Eight further highlight the sharp manner in which Ottawa disengaged financially from Medicare.

What this situation illustrates is the uniqueness of the institutional regimes in each case. In the British case, I have demonstrated above a recourse to a wide variety of policy options, from administrative reorganizations to funding changes to internal reorganizations. Thus, the Thatcher government used a wider selection of policies in bringing about the changes to British health policy it championed in its programme, changes which had their source in the ideology of the New Right. The Mulroney government, however, had only one tool at its disposal, the fiscal lever, but used it more sharply and to greater effect than Mrs Thatcher's. In short, in terms of fiscal policies and how they applied to the health system Mulroney government proved more radical in its pursuit of New Right budgetary measures than the Thatcher government.

This finding is further paradoxical in light of the repeated measures taken by the British government to improve the efficiency and effectiveness of the NHS. Thus, although funding for the NHS did increase between 1979 and 1993 it did so in a policy climate where 'value for money' was a prime directive and a number of major reforms of the Health Service were undertaken with this very goal in mind. The 1982 reorganization of the administrative tiers of the Health Service outlined in Patients First (DHSS, 1979) and the recommendations of the Griffiths Inquiry and the reorganization which followed

Figure 9.1
Comparison of Governmental Contributions to Health Care (NHS and Medicare): Annual Percentage Increase.[1]



(Sources: Health Canada, 1994, Tables 14A and 14B; DHSS, 1985, pp. 15-16; DoH, 1992, pp. 15-16).[2]

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[1] Figures provided are for the whole of the terms in office of both governments. However, conclusions derived from this analysis concern primarily the period between 1984 and 1990.

[2] Figures for Canada and England are based upon actual expenditures [i.e. not real terms]. Figures for Canada were calculated by Health Canada. Figures for 1992 and 1993 are Health Canada estimates. Figures for England were calculated by the author.

were politically sustained by the Government as part of this drive to control costs and expenditures. Similarly, the Internal Market reforms were cast in such a way as to improve overall NHS efficiency and effectiveness through a recourse to market principles and disciplines - although the creation of the Internal Market required the Government to inject additional funds during the implementation phase.

The search for efficiency savings permeated several areas of government policy with regards to the NHS and this concern generated a number of studies and reports all aimed at making the Health Service more expenditure responsive. In short, there existed during this period an intellectual and political climate favourable to expenditure restraint in the NHS. This activity echoed, but did not match, the very real cutbacks in other sectors such as housing and education over the Thatcher reign (Pierson, 1993). In the same way the Government's advocacy of private insurance for health care can be seen to be part of an overall expenditure restraint strategy for, as the Conservative manifesto for 1983 (p. 28) noted, private insurance would "lighten the load on the NHS." Mrs Thatcher herself saw private insurance contributing to the diversion of demand away from the NHS towards the private sector (Thatcher, 1993, pp. 612-613).

A similar climate of restraint permeated the policies and thinking of the Mulroney government. Here the goal of containing expenditures through health care funding restraint was facilitated by the federal-provincial split in jurisdictions. By not having a direct guiding role in the actual expenditures on Medicare the Mulroney government was able to practice blame avoidance (Weaver, 1986) for the outcome of its decisions.

The actions taken by the Mulroney government were very much in keeping with the New Right idiom of expenditure restraint with the goals and rationale underlying this objective were set out in *A New Direction for Canada* (Finance Canada, 1984).

However, in terms of Canada's Medicare system the federal government had only one tool at its disposal in pursuit of expenditure restraint, the EPF. Thus, throughout its two terms in office the Mulroney government modified the formula used to calculate the EPF on three separate occasions (1985, 1987, 1990) and then froze these payments beginning in 1991 (Fréchette, 1993). On the whole the federal government defended its policies as those required by the country's fiscal situation and by the need to preserve social programmes through fiscal prudence (Debates, 26 February 1991, p. 17695). Themes not unheard in Britain.

In short, it is clear that the Mulroney and Thatcher governments pursued fiscal goals which had effects on their respective health care systems. However, this economically liberal proclivity did not entail an assault either on the principles or the broader operations of their health systems. Most importantly, consequent with the New Right advocacy of leaner government, the Mulroney Tories took a different road on health funding than did the Thatcher Conservatives.

Banting (1992) notes that the Canadian and British variants of the New Right differed in their ambitions to change the relations between the state and its citizens. This can be illustrated by a consideration of how both governments' policies reflected the goal of favouring private rather than state provision. Under Mrs Thatcher the private health sector experienced somewhat of a 'boom' (Allsop, 1995) reversing in some instances the policies of the preceding Labour government which had tried to constrain this part of the health sector. In Canada, the recourse to private alternatives was much less an issue and was not championed to the same degree.

With the provinces in charge of the management and administration of the health system the role of the federal government with regards to private sector provision was

fairly limited but highlights one of the ways in which Ottawa tried to 'influence' the health politics agenda. This is because any possible reduction in the role of the public sector is proscribed by the *Canada Health Act*. Although several previously noted reports contributed seemingly favourable opinions regarding private provision, without amending the *Canada Health Act* there was little the federal government could do to increase the private provision of either medical care or ancillary services. However, that the newly elected Mulroney government established these reviews showed it to be receptive to the ideas in currency within the New Right. It will be evident throughout this discussion that this was a particular feature of the Mulroney government - radical options were often discussed but rarely followed upon, thus highlighting the Government's position in between ideological commitment and practical politics. Explanations for this lie in the consensus which supported Medicare, as well as the primarily institutional obstacles that stood in the way of reform.

In contrast the Thatcher governments actively pursued policies which reduced the role of the state while maintaining the NHS within the public domain. Which is not to say that the Thatcher conservatives, and Mrs Thatcher in particular, did not moot certain policy options, even when these tied in with the Government's avowed New Right agenda. Thus, the fate of the CPRS's 1982 health system reform proposals died in a Cabinet meeting (Economist, 9 October 1982; Thatcher, 1993, p. 277). However, a number of measures were taken by the Thatcher government to reduce the participation of the state in the provision of personal health services, for example, through the maintenance of pay beds and the contracting out of ancillary services. Moreover the belief that the private sector did and knew best is also evident in the succession of initiatives which sought to instil in the NHS the management and administrative practices

of the private sector, seen particularly after Griffiths and the Internal Market reforms (Allsop, 1995; Ham, 1992; Klein, 1995). Although Merrison had noted that the NHS could learn from the private sector's more careful attention to the patient/consumer, the Thatcher government greatly amplified this notion to eventually affect the whole of the Health Service.

Therefore, it is evident that while the Mulroney government was rhetorically inclined towards reducing the ambit of the state in health care provision, the Thatcher government matched its rhetoric with action. However, it is unquestioned that the need to soothe the federal-provincial relationship was a major factor explaining the lack of federal action. The Mulroney government's overarching constitutional agenda pre-dominated over any other concern of the federal government - especially in the Government's second term. This was evident in the 'Epp letter' and throughout the nine-year Mulroney administration (particularly noted in personal interview CDN 1). No similar constraint existed for Mrs Thatcher.

A related factor concerns how the New Right conciliated its championing of the market, individual choice and responsibility with the universalist and decommodifying nature of the NHS and Medicare. Decommodification runs counter to the New Right philosophy that individuals should be responsible for their own needs. This belief was particularly evident in Britain (Flynn, 1989), while in Canada this was less so (Banting, 1992). The case of health care, however, is interesting in this instance because it diverges from other elements of social policy throughout the period. In Britain, there was a move away from universality of programmes in favour of means-tested benefits through the social security system, this was seen particularly in the area of housing (Flynn, 1989, pp. 102-103; Pierson, 1993). In Canada a similar movement occurred with programmes such

as the Family Allowance which became means-tested through the introduction of a tax credit (Lightman and Irving, 1991; Evans, 1994). However, while in both the Canadian and British cases the social welfare system was moving increasingly towards a targeted approach, this cannot be said of health. Thus, it appears that Mulroney's "sacred trust" and Thatcher's "safe in our hands" insulated the health system from means-testing. But, although Canada and Britain converged in their continued protection of the universality of health care they diverged with regards to its commodification.

Two aspects are important to note. Firstly, measures that were taken to commodify the health system, such as the introduction of non-tax administrative levies that are used as a revenue raising device for government and, secondly, measures which had an indirect commodifying affect, for example, measures which passed on the cost of a health service from the government to the consumer, either in whole or in part. On both these fronts the Thatcher government was both more active and truer to its New Right philosophy than its Canadian brethren.

In the first instance the Thatcher government proved itself much more willing to have individuals carry a greater share of the costs of health services. This can be seen, for example, in the Thatcher government's decision to delist optical services (Allsop, 1994, p. 164). Increases in prescription and dental charges were another manner in which the Government further commodified health services. Although, charges for prescriptions had been a feature of the NHS since 1949 (Glennerster, 1995, p. 54), their level had always been fairly small. However, under the Thatcher Tories the number of items covered by the NHS declined while at the same time the amount of the charges increased five-fold (see Appleby, 1992, pp. 144-145; also Allsop, 1995, pp. 163-164). Thus, right from Secretary of State Jenkin's unwillingness to consider the Merrison Commission's

recommendation that charges for health services be eliminated (Hansard, 17 July 1979, c. 1793) it was clear that the Thatcher government would consider it legitimate to demand an individual's contributory participation to the cost of their health care - beyond their taxes.

The Thatcher government could also be said to have attempted to make individuals more responsible for their own health services through its championing of the private sector in health care with private insurance as the preferred means of access to private care. Mrs Thatcher was a particularly strong proponent of this approach (Thatcher, 1993, p. 606). Although the Thatcher government balked at moving the whole of the NHS into the private insurance market (Economist, 9 October 1982; Economist 18 September 1982; Thatcher, 1993, p. 277; Lawson, 1992, p. 303), there persisted throughout its terms in office a desire to maintain open a market option for health care.

Such a market option was never truly on the agenda of the Mulroney government, although it was a recurring theme in its backbenches and occasionally its front benches (personal interview CDN 1; Winnipeg Free Press, 21 April 1991). In fact, the public debate in Canada in the late years of the Trudeau Liberal government and the early years of the Mulroney government had often been cast essentially around the issue of user fees, either for hospital stays or through physician extra-billing. However, despite an ideological propensity among its membership to favour curtailing the universality of health services (Perlin, 1985; Martin et al, 1985) and the eagerness of some provinces, such as Québec (La Presse, 14 May 1993), to introduce some user fees for health services, the Mulroney government stood firm in opposition to the introduction of user fees and, through Bill C-20, further strengthened the decommodification of health care, a decision which showed it to be out of step with the New Right policies espoused by its

peers in the United Kingdom. This step taken by the Mulroney government is more so important considering the constitutional and economic factors which could have easily been utilized to defend a decision to amend the *Canada Health Act*. If one considers the principle tenets of New Right thinking, particularly with regards to responsibilizing individuals for their social needs and controlling public expenditure, one would have expected the Mulroney government to encourage a user fee policy. Such a policy would have contributed to the twin goals of pushing the cost of social services back to the individual while also acting either as a deterrent to the use of public health facilities or a non-tax revenue source.[5] However, it is true that policies similar to those pursued by the Thatcher government, such as the delisting of certain services, were also a feature of Canadian health policy at the provincial level. However, because these changes did not contravene the *Canada Health Act* and were entirely within provincial jurisdiction these cannot be said to reflect on the policies of the Mulroney government - except in so far as its funding decisions forced the provinces to re-examine the health services which they offered (see Health Canada, 1994, p. 7).

In short, while there existed some debate, particularly among interest and activist groups, regarding the Mulroney government's determination to uphold and defend the *Canada Health Act* and Medicare, it is a fact that Canada did emerge at the end of the Mulroney regime with its health care system largely unchanged, if much less well-funded. Other aspects of policy which were debated, discussed and/or implemented in Great Britain concerning private insurance and delisting of services were not an issue in Canada largely for institutional reasons. Within its strictly constitutionally limited

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[5] Manga and Weller (1991) claim this as the first tenet of Canadian Tory policy. However, as I argued above, although this theme was present in the background of Tory policy it did not come to the forefront of policy options examined by the Mulroney government due to both practical (personal interview CDN 5) and political reasons (personal interview CDN 1).

area of jurisdiction the Mulroney government can be said to have preserved the decommodification of Canada's health care system. Again, the Canadian Tory government's ideological stripes did not run deep below the surface.

Overall, while both the Mulroney and Thatcher governments can be said to have been true to the New Right idiom a divergence exists in how extensively each government pursued this in actual policy. Thus, I have shown that the Canadian and British cases diverge with regards to the curtailment of public expenditure for health. Additionally, I have shown that the British government was much more active in championing policies aimed at increasing the role and ambit of the private sector and in the increasing the commodification of the health system. Explanations for this divergence are primarily institutional in so far as the Mulroney government had a different role in the health system and had in its possession much fewer policy tools than its British counterparts. However, where it did have both the policy tools and jurisdiction, i.e. funding, it was a much stronger advocate of New Right policy than the Thatcher government.

9.2 Institutionalism and health policy

The previous section concerned the influence of the New Right in the determination of public policy with particular reference to the case of the health care system. But, while the ideology of the New Right may be said to have affected the course of social policy in Canada and Britain, the changes initiated by the Mulroney and Thatcher governments needed to be channelled through and implemented by the institutions of their respective states. It is at the institutional level that some of the most

interesting points of convergence and divergence between the two cases appear, particularly with regards to the financing of the health system.

Common to both our cases is Hall's (1992) first level of analysis, capitalism and liberal democracy. Although, to quote Hall, these "impose broad constraints" on policy outcomes (1992, p. 96), they are also the weakest and most general of institutional features. Thus, while it can be said that the response of the British and Canadian governments to the crisis of the Keynesian-Beveridge model was conditioned by liberal-democracy and capitalism, these were not in themselves the primary catalysts. Where this level of analysis is most useful is in terms of Therborn and Roebroek's (1986), thesis of welfare state irreversibility. For these authors, the broad coalition (consensus) of individuals who benefit from the welfare state can be channelled into an electoral coalition which serves to defeat attempts to roll it back. This same logic I submit can be used here as a possible explanation for the soft approach which the New Right in Canada and Britain used in dealing with the public health care system. However, although Therborn and Roebroek (1986) offer an institutionally based argument, theirs is one which focuses on explaining a similarity of outcome while Hall concerns himself with finding the causes for differences in outcomes.

A more useful level of analysis provided by Hall is that of the organization of socio-political and economic activity, for example, the presence or absence of trade unions or the level of concentration of capital. In this study the key institutional difference between the British and Canadian cases resides in their respective political structures. The British state is institutionally centralized and this centralization, particularly under Thatcher, has made the state a much more effective political agent of

change (King, 1992, p. 221) while the Canadian state is highly decentralized (Stevenson, 1988, pp. 35-38). This analysis can be extended to this comparison.

At the most basic level the policy changes applied to Medicare and the NHS were greatly facilitated by the Westminster and Cabinet models of government in both countries. On this score I previously cited Klein's (1995) argument that Britain's health reforms were aided by the hegemony offered by Parliament over other actors in the political arena. While this conclusion is undoubtedly true in the UK, in Canada the presence of a sub-national level of government - with clearly defined fields of jurisdiction and related taxing powers - unquestionably weakens the role of Parliament in the Canadian context. Here, with solid majorities in both London and Ottawa, one needs to look beyond the legislatures for contending poles of opposition. In Britain, although some veto points existed outside of government, but these were comparably weak. Health sector interests remained disaggregated, generally by professional divisions, and therefore did not offer much opposition to the Government's policies. The single-payer aspect of the NHS also insured that no contending pole of attraction existed for opposition to coalesce, with the possible exception of the private health care sector. In short, one of the reasons that Thatcher was able to be so active in health policy was the lack of institutional vetoes. In Canada, although health sector interests retained better access to policy makers their influence on policy remained small. Thus, the natural point of opposition to Ottawa's policies resided with the provincial governments. However, by carefully ensuring that its policies remained within its area of jurisdiction the federal government avoided much of this potential opposition on terrain not its own.

This is not to say that the Thatcher government could act with impunity in NHS reforms. What prevented far more radical reforms of the NHS, such as those proposed by

the CPRS in 1982, was the practical politics of public opinion. Because the "rules of the game" (Immergut, 1992a) required the Government to seek regular recourse to electoral results to validate its policies, the lack of public support for wholesale NHS reform served as a veto point. In short, the need to remain in power to realize other elements of their agenda meant that the Thatcher Tories had to moderate their intentions with regards to the NHS. As noted above, this situation bears out the thesis proposed by Therborn and Roebroek and may in itself explain why radical reforms of the NHS were kept until the end of the Thatcher government's third mandate.

As for the Mulroney government its actions were limited by the diffusion of interests across the political system leading to a multiplicity of voices which it needed to accommodate. A centralized political system, such as that of Britain, enables the government to consult widely with interested parties and, if it chooses, to forge a national consensus behind its policies. On the other hand, the fragmentation of the Canadian state and the diffusion of powers across the provincial governments and the regional identities inherent in a country composed of two nations and stretching across the width of a continent made this type of accommodation more difficult. Thus, for example the British government has one main interlocutor for the medical profession, the BMA. In the Canadian case there are not one but thirteen different medical associations (ten provincial, two territorial and one national, the CMA). This pattern of interest representation was replicated across the policy field. Moreover, provincial affiliates could - and did - champion policies not supported by the national CMA and vice versa (personal interview CDN 16). Trying to achieve any sort of national accommodation is, if not fraught with perils, at least difficult. However, as the Mulroney government's goal was not so much to reform health care as to address what it perceived as its fiscal problems, this diffusion of

interests and representation facilitated its policy drive and blunted opposition. But, although in the Canadian case it could be argued that the real level of decision making is that of the provinces, it remains that the federal government continued to be a participant in Canada's health system through its role in defining both the principles of Medicare and contributing to its funding. It is important to note here that while the NHS could be seen as an instrument of national integration and, especially after WWII, reconstruction, in Canada social policy has been one of the major elements in state building and unifying national institution (Banting, 1991). This goal justified in large part the federal decision to enter the area of provincial jurisdiction. However, as the nationwide composition of interest groups highlights, in order to maintain this national policy the federal government was required to deal with several, often contradictory, interests.

The respective natures of the British and Canadian political systems can also be said to have affected the process of policy change. In Britain, it can be said that the pattern of party competition was marked by a clear Left-Right divide between its two main political parties. On the whole the approach to policy and the source of support for each party are widely different - which Mrs Thatcher attempted to bridge with appeals to nationalism and populism. In Canada, the brokerage model of politics has tended to minimize the ideological differences between the Liberal and Conservative parties. Both appeal to the middle ground in the Canadian electorate although historically the Liberals have done so from a position slightly Left of the Centre. As a result both parties have courted the public with policies which on the whole have not shown the same type of ideological spread as existed in Britain between the Labour and Conservative parties. Moreover, unlike in Britain where the social democratic Left is the natural contender for power to the Conservatives, in Canada the social democratic party is a third party

although it has influenced public policy, particularly in matters relating to social policy (Maioni, 1994). As such, the tensions in Canada's political system concerning the welfare state have been minimized and occur between two parties vying for the political centre while in Britain the welfare state is integral to the ideological division between Labour and the Conservatives - although with regards to the NHS the Thatcher Tories took a more pragmatic orientation than they did in other sectors of public policy.

In Canada, although the development of social programmes was clearly the product of Liberal governments, the Conservatives none the less played a role in their development and maintenance, much as the Post-War British Conservatives had done. Part of this can be explained by considering the internal Left-Right splits with the Canadian and British Conservative parties where the 'wets' and 'Red Tories' influenced policy and acted as a brake to the policies promoted by their colleagues further on the Right.

Politically, the health systems of both countries appears to fall astride the ideological fault lines between parties, which partly explains the lack of rollback of the NHS and Medicare between 1979 and 1993. However, it is also true that the Thatcher government tried harder than its Canadian counterpart to instil in the NHS principles and administrative structures which resembled its preference for market mechanisms and limited government - although these were grafted upon a system still very much within the state's ambit. Also, the lack of rollback in the NHS and Medicare could be said to be the result of their identification with the policies and legacy of the Labour and Liberal parties. These parties continued to promote and defend the health system and they were well aware of the political appeal which the NHS and Medicare had with the electorate.

Finally, Hall's third level of institutional analysis is that of the "operating procedures" of the state. At this level policy change was limited or constrained by formal requirements, but facilitated where informal avenues exist (Hall, 1992, p. 97). The majority of the changes which affected the NHS during the Thatcher governments were achieved through the formal legislative process. However, the Thatcher government also distinguished itself for its use of less formal, "but no less potent" (Hall, 1992, p. 97) methods to achieve its ends. For example, as Sir Roy Griffiths himself noted, many of the changes envisioned by the recommendations of his 1982 Report were meant to be pursued without recourse to legislation (Social Services Committee, 1984, p. 142). In another context, the Thatcher government's frequent recourse to specific-focused and short term inquiries, such as Griffiths or the 1987 Ministerial Review, rather than full scale Royal Commissions had two advantages: Firstly, they were quick and generally seemed to be driven by a need to provide policy recommendations rather than endless analysis; secondly, by not opting for large Royal Commission's and Green Papers the Government was ensuring that it deprived its opponents of a platform against the reforms (Pihan and Curtice, 1994). Thus, the informal process of consultation and review ensured that the Government's policies did not face obstructive commentary on their way to the legislation stage.

The Canadian government for its part faced institutional obstacles that the British government was able to by-pass. For example, because its changes to the EPF needed to be legislated as part of the larger budget implementation bills, the Mulroney government's policies were open to parliamentary scrutiny and, moreover, were effectively debated due the opposition's parliamentary privilege to reply to the budget. Moreover, the nature of federal-provincial relations ensured that federal government policies regarding the EPF

would be greeted by statements from the provincial capitals and be raised at federal-provincial meetings of finance and health ministers. The outcome of federal government policy may have been stealthy, but the means to their implementation certainly was not. The only informal means of action open to the federal government consisted of its enforcement of the *Canada Health Act* where, it appears, it acted with less diligence than had been envisaged when the Act was passed in 1984 or since the 1994 change in government (personal interview CDN 15; CDN 16). But most importantly perhaps, it is the fact that the British government was the sole actor in all facets of the health system while the Canadian government's role was limited to its funding that determined the divergence in policy change between them.

Institutional factors also facilitated the Mulroney government's hard stance on restraining the growth of funding for health care. It must be recalled that while the federal government entered this field in the 1950s through the use of its spending power, health has remained entirely within provincial jurisdiction. Thus, while the *Canada Health Act* constrains the provinces to a degree, this constraint is entirely financial. A provincial government could theoretically, but only at significant political and fiscal risk, opt out entirely of EPF transfers. While Canadians symbolically see Medicare in national terms, their relationship to the system is entirely through their provincial health insurance system. The decisions that affect their local hospital, for example, they know are taken in their provincial capital.[6] What this means in practical terms was that the federal government was able to pursue its cost restraint policies but avoided blame for its

[6] It is worth recalling here that one of the regulations stipulated by the *Canada Health Act* but never enacted by the Mulroney government concerned recognition of federal contributions. In short, the federal government was acutely aware that while its funds were critical to the operation of the health system, it was invisible to most Canadians (personal interview CDN 16; Canada, 1985a, Chapter 6, section 13). Why this regulation was never enacted is unknown.

outcome. As one interviewee noted, "nobody blames the feds for closed beds" (personal interview CDN 2) - recalling Weaver's "blame avoidance" politics. In short, the institutional structures of Canada provided the Mulroney government with an opportunity to affect the health system through policies which posed less risk to itself politically. In this sense one could argue that amending the *Canada Health Act*, for example, would have raised the awareness of the federal role in health and, potentially, raised opposition against such a move amongst the electorate which, Therborn and Roebroek submit, defends the welfare state from rollback.

The situation in Britain was much different. Here the Thatcher government could not hide behind a jurisdictional argument to defend its policies. While the Canadian ministers frequently reminded critics that responsibility for health care was a provincial jurisdiction, in Britain the Secretary of State held parliamentary accountability for all aspects of the NHS. This factor limited the Government's ambit for NHS reform to changes which they believed would not endanger their chances for re-election. For example, Mrs Thatcher's concern over the difficulties in implementing the Internal Market in 1987 (Independent, 10 July 1995) highlights this very point. Where institutional regimes permit governments to act in the shadows, so to speak, they will act more radically. Thus, the steadily increasing level of funding for the NHS between 1979 and 1990 can be seen as a reaction to - and a realization of - political imperatives. However, as other programmes discussed previously show, it is not sufficient to have a unitary form of government to be able to push through major public policy reforms. In Britain, although sectors such as housing experienced major rollback, health did not. In other words, while the concentration of power in Britain significantly aided the process of health policy change - this advantage could equally turn into a liability as Westminster

could not readily put the blame for policy failures onto other actors. In Canada, although a federal system with its widely dispersed governmental powers, the Mulroney Tories were quite successful in reducing the growth rate in federal health expenditure. What the preceding discussion suggests is the usefulness of the concentration on the political system as a public policy shaping instrument, but also its limitations.

In short, it is clear that institutions matter, especially in the light of this comparative study, however, to repeat Thelen and Steinmo's observation (1992, p. 3), "they are never the 'sole' cause of outcomes." What this case study highlights is the enhanced ability of a government to affect change where the lines of political/jurisdictional responsibility are direct.

9.3 Conservatism and health policy

An interesting issue related to the preceding discussion is that of the relationship between the ideology of the New Right as practised by the Mulroney and Thatcher governments and how it ties back with the intellectual traditions of Canadian and British Conservatism (or Toryism). As I argued above there appears to be in both cases a disjunction between New Right policy rhetoric and policy action. One of the central aspects of the irreversibility thesis is its reliance on the existence of an electorate which will sustain and protect the welfare state from rollback. However, it is also possible to add to this explanation the importance of the ideological traditions of both Canada and Britain and how this contributed to the creation of an electoral consensus behind the welfare state.

Traditional Conservatism in both Canada and Britain accepted the need for state intervention in the protection of society's weakest members. The NHS had its roots in the

Conservative dominated wartime coalition government, and in Canada the Conservative Party's progressive wing had always supported the gradual extension of Medicare. Brian Mulroney's declaration that Canada's universal social programmes were a "sacred trust" and Mrs Thatcher's oft misquoted statement that the NHS was "safe with us" were both, beyond being a recognition of political necessity, rooted in the philosophical traditions of both parties.

However, although philosophical tradition is part of the explanation for the lack of 'bite' exhibited by both Conservative governments, the nature of Canada's party politics is an important institutional factor which needs to be highlighted. The socio-political unifying effect of Medicare as a defining characteristic of national identity (see Maclean's, 1 July 1994) ties the limitations placed on Mulroney government policies in health with the brokerage model of Canadian politics. While it is true that there was an ascendancy of New Right politics in some provinces before the election of the federal Tories (see for example Marchak, 1990) and after, as this study demonstrates the Mulroney government continued to uphold the principles of Medicare and strengthened them through C-20. The explanation for this state of affairs is rooted in the necessity for federal politics to champion policies which find appeal across the regional, 'national' and other cleavages in Canadian society.[7] In others words, it is difficult to divorce the traditional philosophy of Canada's Tories from the model of electoral politics within which it operates. Such a recourse to non-class based politics is not an element of traditional British Conservatism.

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[7] In the 1993 election the Liberal Party was elected thanks to this broad based brokered appeal. However, the opposition benches are largely filled with MPs whose parties, the Reform Party and the Bloc Québécois, find their support in appealing to these cleavages (Erickson, 1995).

At issue here is also the question of how the Conservatism of Mulroney and Thatcher compared with that of their predecessors. As noted above the ideological roots of both Conservative parties do not have only one strain and at different times in their history they articulated their policies and programmes around different themes. Thus in Canada the party swung between business-liberalism and a more interventionist form of Toryism, as did the British party. As the literature highlights, Thatcherism had a diffuse nature which was evident in the policies that it pursued - applying hard New Right solutions such as privatization while pursuing policies not all that inconsistent with those of the Post-War governments, particularly with regards to the NHS. Thus, Thatcherism's diffuseness was consistent with the statecraft of the British Conservative Party and it was this, over and above its ideological disposition, which defined Conservatism in Britain after 1979 (Gamble, 1988).

Contrasted to Thatcherism, the Conservatism espoused by Brian Mulroney and his party appears less doctrinaire and less radical. Overall Mulroney's adoption of New Right policies was mainly focused on privatizations, trade and fiscal initiatives - the latter being the area touching on health. Athough the Mulroney party articulated a more business-liberal oriented set of policies, this orientation was not geared towards a larger socio-economic and political project. Unlike Thatcher Mulroney did not want to change Canadian society. On Medicare the Mulroney Tories differed little from the traditional Toryism which had guided the party since the War and, as the passage of C-20 showed, the party was not above pursuing policies of the Centre-Left as this was entirely consistent with the history of the Canadian party in the Post-War. Part of this moderation maybe a reaction to the success of the Liberal Party in maintaining power through its centrist appeal.

With regards to the health system both the Mulroney and Thatcher Tories applied policies that were pragmatic and consistent with the consensus surrounding this institution, although the Thatcher government was able to alter the NHS' internal workings to a greater extent than could its Canadian counterparts. Beyond the specific focus of this research, however, it is clear that the Thatcher version of Conservatism was much more far reaching in its attempt to change society and economy (see Banting, 1992).

Thus while the ascendancy of the New Right in both Canada and Britain marked a clear shift in the overt politics of Conservatism, the covert philosophical traditions, I submit, continued to have an impact on the course of policy change. In the end, and more so in the case of the Thatcher government, which held a much stronger Hayekian line than the Canadian Tories, when it came to health care reform both the Canadian and British Tories exhibited the politics of pragmatism rather than those of ideological purity. A pragmatism not far removed from the ideological heritage of both parties.

9.4 Incrementalism and health policy

My analysis now turns to the theme of incrementalism in policy making. I will argue below that while the developments in Canadian health policy have been consistent with the incrementalist approach, incrementalism cannot account for the broader changes which occurred in Britain's health system. This divergence will be partly explained by differences in the policy tools available to each government. As it was found that incrementalism is a limited analytical tool, I will argue below that an alternative might be found in punctuated equilibria.

The Thatcher government's record in health care shows two distinct periods in the development of policy. Prior to 1987 the Thatcher government could not be said to have actively pursued a reform agenda with regards to the NHS (personal interview GB 6), with the possible exception of General Management. It is only after 1987 and faced with an apparent crisis in the Health Service that Mrs Thatcher decided to initiate a review of the NHS, leading to a broad reform of its structure and administration. Between these periods the Thatcher government's policies show a series of successive incremental steps such as changes to charges, the delisting of certain services, etc., which served a longer term goal, that of expenditure control and restraint. Thus, the longer term goal of financing social policy in general, and the health system in particular, was pursued through incremental means. Moreover, because so much of NHS policy concerns its budgetary allocation it is difficult to discuss incrementalism without a consideration of the Government's budgetary policies in so far as they affected the Health Service. In this sense it is possible to see successive changes to the financing of the NHS, for example the changes in the prescription charge, as part of this larger process of increasing or decreasing line items "within a narrow range" (Dempster and Wildavsky, 1979, p. 372, citing Wildavsky).

However, the limitations of incremental analysis are all too evident in its failure to explain major policy departures such as General Management and the Internal Market, to which one might be tempted to add the 1982 administrative reorganization. While there is in the British case an incrementalist pursuit of fiscally defined longer term goals, a series of larger changes break with this pattern. There is a disjunction between policies moving at different speeds. For example, the decision to increase the prescription charge was a slow change towards the longer term goal (an increment), but the introduction of

General Management was a larger change which classical incrementalism cannot account for entirely. However, it is useful to note that while there may not have been a clear 'policy chain' many of the 'Big' changes which occurred in the NHS could not have been contemplated had previous smaller steps not been taken (personal interview GB 7).

In the Canadian case, the Mulroney government exhibited a tendency towards incrementalist expenditure decision making (Savoie, 1990, p. 633). Thus rather than attempt a wholesale withdrawal of the federal government from the health policy area which would have been a major policy departure, the Mulroney Tories proceeded through a series of budgetary changes that restrained transfers to the provinces. This is a particularly good example to budgetary incrementalism (Wildavsky, 1964) in the sense that the Mulroney government's health policies largely represented changes in its year to year funding of Medicare. Particularly with the freeze of 1991 it was the case that the size of the annual budget was largely determined by the size of the previous year's.

According to the incrementalists, change will happen slowly due to institutional rigidities. These rigidities can be related back to my discussion of institutionalism and particularly Immergut's (1992a) notion of veto points. Therefore, for the incrementalists change occurs slowly because institutions and interests create obstacles. A good example of this is the manner in which federalism constrained policy change in health. In health policy, particularly, other obstacles to rapid change are found in the presence of organized groups of professional interests, the existence of a wide supportive consensus (or coalition of interests) committed to health insurance, and a political system where effective policy making power is sometimes diffused or subject to public approbation through election. However, as I have shown, the presence of these interests - either professional or public - can be, but need not always be, a constraint. The manner in

which these sector interests were effectively taken out of the policy development and implementation process of the internal market highlights this. Governments can, and do, choose who to invite to the discussion table when developing policy. Although it is true that the provider interests are sometimes successful in acting as brakes to policy drives - as the case of HEAL in Canada demonstrates - if they act in unison rather than separately.

As I noted above, the NHS and Medicare were both cocooned within a supportive consensus which acted as a brake to the government's reform drives. However, while this could be contributory to incremental policy making, the Thatcher government was none the less able to act swiftly and broadly in its reforms. This was achieved through policies which did not strike at the heart of this consensus. The best example of this is the Internal Market. Although these reforms had a wide-ranging effect on the NHS they did not change the principles of the Service or the manner in which individuals would come in contact with it. The Service remained free, comprehensive and universal. However, its internal workings were quite dramatically altered with the introduction of General Management and the Internal Market.

The contrast between Canada and Britain in terms of incremental analysis, especially in the light of the previous discussion concerning the place of New Right thinking in their respective policies, is most interesting if one extends the analysis to other areas of social policy. Although the Thatcher government came to power pledging to break with the Labour past many of its reforms, for example in housing (Flynn, 1989), were instituted incrementally. Thus, although the British government was keen to withdraw itself from the provision of housing it took seventeen pieces of legislation over nine years to achieve this goal (Williams, 1992, p. 165). However, it appears that policy change under Mrs Thatcher moved at two different speeds for while sectors such as

housing were incrementally reformed in health the process was not incremental. The fact that policy change in the NHS does not conform to incrementalism can be seen as an indication of the limitation of this model's applicability to explain policy change. The contrast between housing and health also permits the further theorization that incremental policy change is best suited to rollback while the non-incrementalist approach is best suited where the basic entitlements are unaffected but the administrative structures are changed. In Canada, constrained by political buffers relating to both the political and institutional factors and the type of policy changes pursued, incrementalism was the *modus operandi* of the New Right.

As my study of British health policy has shown the utility of incrementalism as a theoretical tool in policy analysis needs to be re-examined. One suggested alternative which retains certain aspects of incrementalism while offering sounder grounding to explain radical policy changes is punctuated equilibria (Eldredge and Gould, 1972).

While there is in the British case an incrementalist pursuit of a fiscally defined longer term goal a series of larger changes break with this pattern. In short there is a policy disjuncture between the policies moving a moving at different speeds, for example, the decision to increase the prescription charge was a slow change towards the longer term goal (an increment), but the introduction of the three reforms discussed above are larger changes for which classical incrementalism cannot account for entirely. Kingdon captures this important feature about the public policy environment, "the agenda changes suddenly and non-incrementally, which makes agenda-setting look like punctuated equilibrium. But the alternatives are developed gradually" (Kingdon, 1994, pp. 227).

It is my submission that punctuated equilibria is a more realistic theoretical framework within which more detailed explanations of non-incremental policy change

can be accommodated. As outlined by Eldredge and Gould, punctuated equilibria sets out a model where the policy process can be seen as composed of periods of sudden fits and starts (punctuations) and periods of consolidation or stasis (equilibria). Where incrementalism seems lacking to explain radical breaks with pre-existing policy punctuated equilibria can account for these fundamental changes in policy - or 'Big Change'. In addition, punctuated equilibria appears to present all the advantages which had been once ascribed by Dror (1964) to incrementalism; it mirrors real life, is akin to human nature and appears, as this case study highlights, to reflect actual examples of public policy.

However, it is important to guard future research from concept stretching. As Eldredge and Gould note theory may blind us to the reality in nature (1972, p. 83).[8] Therefore, before rejecting out of hand incrementalism as a policy model it may be useful to replicate this study in other areas of public policy and, more importantly, across polities either in single country studies or in a comparative framework. By doing so the problem of ethnocentric blinkers, particularly, will be minimized and a better picture of the salience of punctuated equilibria to the social sciences will emerge. In the meantime, the conclusion to this study is that punctuated equilibria is useful and accurate contribution to the policy sciences.

9.5 Interest group politics and health policy

As I noted previously, much of the research in health politics has focused on the participation of interest groups[9] in the policy process (as examples of this tradition see

[8] An interesting case for theory affecting findings in the social sciences is also made by Dowding (1995) in his critique of the policy networks model.

[9] For the purposes of this discussion the groups discussed below are those concerned exclusively or having a clear stake in the health system. While the participation of other 'non-health' interests was raised

Klein, 1995; Eckstein, 1960; Taylor, 1960). Although this tradition is useful as the background to the study of the health policies pursued in the 1980s and 1990s by the Canadian and British governments, it has been my contention throughout that institutional structures are a greater determinant to policy outputs than interest groups activity.

The main contrast between Canada and Britain with regards to interest groups and health centres around the existence of interest coalitions in the former and their absence in the latter. My purpose here will be to describe the process of common interests grouping together in support of a particular policy outcome and posit some reasons why these coalitions formed in Canada but not in Britain. Two different types of coalitions will be discussed below, trade union dominated and professional/stakeholder dominated.

As noted previously, British interest groups in the health sector have shied away from forming coalitions despite a shared general opposition to many of the policies of the Thatcher government - in particular the Internal Market. Two factors explain this - the division caused by trade unionism and secondly, and relatedly, the Left-Right tension which exists among health sector interests. For example, COHSE and the BMA were divided by differing status within the NHS and differing demands when it came to the distribution of the NHS' resources. Even among trade unions coalition building was difficult as unions differed on tactical as well as economic issues. For example, the Royal College of Nursing's (RCN) pledged not to engage in industrial action while COHSE did not have a similar pledge (personal interview GB 9). This made collaboration difficult as the strategies of each organization were largely defined by their public approaches to conflicts with the Government.

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earlier, in the interest of clarity, think tanks and business groups, for example, are not considered below.

Ideological differences, as those between the RCN and COHSE, also made coalition building difficult. Thus COHSE's membership of the TUC and its open affiliation with the Labour Party separated it from non-political organizations such as the RCN and the BMA. Similarly, professional differences, particularly between doctors and other professional groups, hindered coalition building as did distributive tensions among British interest groups. Thus, because groups and associations in Britain were locked in to having to bargain nationally with the Government, and often to the detriment of other actors, for their economic or professional advantage coalition building was more difficult. This was a constraint which national associations and groups in Canada did not face. As bargaining took place primarily with the provincial governments HEAL could conciliate at the national level what would be jealously guarded patches at the provincial. In fact, coalition building at the national level may have restored influence lost at the provincial level. Another factor explaining the lack of coalitions in Britain has to do with the type of reform programme which the groups were facing. Thus, in Canada, federal government policy was limited to only two areas, the *Canada Health Act* and the EPF. In the British case however, the broader ambit of the reforms envisaged and implemented by the Thatcher government obviously made the establishment of set common positions somewhat more difficult.

In Canada, although distributive tensions were mostly absent from national group activity, federalism posed a challenge to coalition building. As noted above, the federal nature of the country was replicated in the pattern of health interest organization and representation. This hampered the development of national policy development on the part of interest groups - in this case distributive tensions were replaced with regional tensions - but paradoxically facilitated national issues, such as economic ones, being

addressed at the provincial rather than the federal level. Tensions which did exist at the national level - among the different providers for example - were put aside with the realization that the Mulroney government was not interested in dealing with groups individually.

Thus, it is interesting that in both cases health sector interests were faced with unresponsive governments intent on keeping the health policy sector relatively closed, but only in Canada was the group response the movement towards a joint approach.

What emerges from this study is the limited role which interest groups played in the development of the health policies of Mulroney and Thatcher. In neither case were the Governments particularly open to negotiating with outside interests regarding the future of the health system, nor were they interested in receiving their contributions. In the Canadian case, this exclusion also appeared to include the provinces, who were kept equally in the dark about the changes the federal government was planning.

While the interest of consumers/patients was frequently mentioned as the rationale behind some of the Thatcher government's policies, as can be seen in the titles of some of the documents issued by the Government,[10] the extent to which representatives of patients groups, community health or public health groups had access to decision makers was just as limited (personal interviews GB 4; GB 8). In short, rather than see policy making becoming "parcelled out," as Pross (1986) suggests, under the Mulroney and Thatcher governments it appeared that the policy making process became much more centralized and limited to a small segment of the overall community. Part of the reason for this situation may lie in the nature of the interventions of the health care interests. In the Canadian case one of the main reasons underlying HEAL's success at getting the ear of

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[10] For example *Patients First* (DHSS, 1979) and *Working for Patients* (DoH, 1989).

politicians and senior officials was its decision to deal with the issue of health care on the same terms as the Government. Thus, rather than confine itself to the usual list of health care sector "demands" it expanded its purview to include the issue of the debt and deficit. By adopting a broader view of the health system HEAL was able to become a credible interlocutor with government rather than simply a disruptive pressure group, as the CHC was perceived (personal interviews CDN 1; CDN 11). An attempt in this direction was made by the BMA in its contribution to the discussions following the release of *Working for Patients*, but by that point the division lines ran too deep.

In short, in the 1980s, with governments on both sides of the Atlantic primarily concerned with the fiscal and economic consequences of the welfare state it appears the participation of groups which had contributed to its building and management was no longer welcome or encouraged. Rather, the 1980s seemed to mark a period of diminishing influence for professionals, stakeholders, social and trade union groups. While they were never entirely shut out of the policy development process they appear not to have been the effective sources of policy alternatives. This conclusion has important ramifications to our understanding of Post-War politics. While my conclusions regarding interest groups are temporally and sectorally confined, they point to a need to reconsider many of the interest groups grounded theories and models which have guided Post-War political enquiry.

9.6 Irreversibility and health

The previous discussion focused on the effect of New Right policies and ideology on the British and Canadian public health care systems and tied these into the wider politics of the welfare state. One of the threads running through the previous discussion

is the lack of a social welfare rollback in the area of health care. I have ascribed this development as evidence of the validity of Therborn and Roebroek's (1986) thesis of welfare state irreversibility.

In the Canadian and British cases it is true that both governments pursued policies detrimental to certain aspects of the welfare state. In Canada this was primarily in the areas of pensions, Family Allowances, and Unemployment Insurance, while in Britain this occurred primarily in the housing, education, and social security benefits sectors. In Canada and Britain, programmes have become increasingly means tested rather than universal or have been retrenched (Evans, 1994; Flynn, 1989). In both cases these changes could be seen as a reflection of the preference for a residual model of the welfare state common in other Anglo-Saxon nations (Esping-Andersen, 1990a and 1990b). Although neither Canada nor Britain had fully universalistic models of the welfare state Britain came closest to this model. However, where Canada and Britain did pursue such a model, in health care for example, it has proved tremendously resistant and resilient and has emerged rather intact from over ten years of New Right government. Moreover, with strong public support in both countries for universal medical care, any temptation to dismantle this sector of the welfare state proved politically difficult.

Thus, I propose that although the Mulroney and Thatcher governments were willing to experiment with means testing and residualisation of some programmes, the wide political and social consensus surrounding Medicare and the NHS insulated these against New Right attack. This is more so sustained by the Mulroney government's decision to make all federal transfers subject to garnishment for infringements of the *Canada Health Act*. Had it been inclined to follow its New Right idiom, weakening the *Canada Health Act* would have been an eminently preferable option to altering the

funding regime. It must be recalled that the Act sets out the principles of Medicare, including universality and decommodification. Instead, by broadening the definition of the transfers which could be withheld the federal government was making stronger the symbolic and political role of the Act. In Britain, Mrs Thatcher's rejection of the CPRS 1982 reform proposals and her reaffirmation of the NHS's principles in the Foreword to *Working for Patients* highlight similar motivations. In short, while one cannot discount the various pronouncements of members of the British and Canadian Tory governments with regards to the rollback of the welfare state, it appears that in the case of health care the Tory bark was not matched by a Tory bite.

In closing, this study of Canadian and British health policy under New Right government largely confirms Therborn and Roebroek's postulates for welfare state irreversibility. As in their study, I have found a strong commitment on the part of the Canadian and British publics which acted as a brake to policies which might have led to the dismantling of the NHS and Medicare. In both Canada and Britain, politicians deferred to this consensus in their health policies. Moreover, as I showed with my discussion of housing in Britain and the OAS in Canada, the universal nature of a social programme and the level of public attachment to it is one of the main factors explaining policy outcomes. Again, this conclusion agrees with that of Therborn and Roebroek.

9.7 Limits of this research and areas for future study

This study does not pretend to be either a complete nor conclusive discussion of the impact of the Thatcher and Mulroney variants of Conservatism on the development of health policy. Many questions and issues remain unexamined. Furthermore, in the course of this study I have become aware that a number of other avenues for further

research arise from the issues which I have pursued here. In considering these issues the reader is reminded of the methodological issues which I raise in the Annex, in particular with regards to the difficulties encountered in the course of this research.

This study's main limitation relates to its framework of analysis. I have adopted a comparative history approach to which other approaches have been grafted where relevant. I have therefore attempted to contextualize and to textualize a rich field of investigation. As such, this study does not contribute to theory building, nor does it provide a grand theory of health policy or welfare state change that is applicable across time or polities.

Possible avenues for further research are clearly too many to count. Simply changing the theoretical focus of the study, for example using a Marxist or a policy networks approach, will of itself provide a multiplicity of avenues for new research. However, I suggest that three main avenues of research would go a long way to filling the previously identified gaps as well as extending the original research question.

The first avenue for further research is one where the same comparative is retained but the field of policy is broadened to include other parts of the welfare state in the comparison. For example, what was the impact of the New Right on education or pension policy under these governments. Such a focus would bridge the gap between my macro-political focus and the micro-policies pursued by the Mulroney and Thatcher governments. Another avenue for research would consider the provincial level of government in the steering of health policies. By extending to this level of government the research aim of this study I believe one may arrive at a more complete picture of policy change. This type of research should be conducted in terms of cross-'national' comparison, although single province studies would also be interesting. Additionally, as

the Canadian provinces are for all intents and purpose sovereign when it comes to administering the health system, a cross-national study involving a comparison of provincial health policies with those of European states, such as the United Kingdom, would also be interesting. In this regard the OECD has already contributed a number of studies on the development of 'internal markets' in health care across its members (OECD, 1995). My proposal is to breakdown this analysis further.

Should one prefer to continue focusing on the federal level of government in Canada an extension of the institutionalist approach considered above might contrast the influence of the New Right between Canada and other federal states - particularly where health is a similarly shared area of policy. Obvious cases for such a comparative research might include Australia, Germany, Spain, and even the United States, although the inclusion of the latter might take the focus of the study into a consideration of the obstacles to policy change.

9.8 Concluding statement

This study examined the problem of the impact of the New Right on public policy. It was found that in both Canada and Britain the expected rollbacks of the welfare state did not materialize, although greater policy activity was found in the case of Britain. In the main this research points to an important contrast between Canada and Britain with regards to the impact which institutions and the party political system have in the process of policy change. This finding suggests the need for a more catholic approach to the study of public policy making which takes account of the multiplicity of factors - both exogenous and endogenous - which channel, curtail or facilitate policy making.

In the end, this period in health policy has largely been one marked in Canada and Great Britain by stability in the health policy area in terms of the principles which underlie the NHS and Medicare. The period of Conservative government in both countries has not meant a dramatic shift away from these principles. In short, if, as I did, one focuses exclusively on the health system one may be suitably impressed by its 'irreversible' nature. This analysis does not include the other aspects of the welfare state of which Medicare and the NHS are only one part. Perhaps the problem for the social democratic left is its fixation with the symbolic functions of individual elements of the welfare state (health, pensions, education, etc.) without regard to their interaction. A focus which I would liken to concern about the health of an individual tree with little regard for the health of the forest. The Black Report stands out in this regard as an attempt to recognize the interaction of social policies. Thus in Canada and Britain, while both Medicare and the NHS withstood the New Right, other parts of the social menu were 'reformed' - some becoming almost inconsequential. Housing in Britain being a prime example. Which returns me to the issue of the health system. Certainly if Aneurin Bevan and Tommy Douglas where with us today they would recognize the NHS and Medicare's principles and operation. But neither man was content in his time to seek only a health system in preference over action on the other ills of our societies. Yet this is where the New Right, and the New Left, has sunk us, for we have abdicated the whole for a defence of the particular. If Bevan and Douglas were with us today would they recognize as theirs the values of the politics of social welfare in the 1990s? I fear not.

Annex:

Methodology and the Comparative Method

This study falls between two genres of political research, that is the single-state study and the comparative study. On the one hand this thesis presents stand alone discussions and analysis of the developments in health policy in Canada and the UK according to the research and theoretical themes outlined above. On the other hand, I have juxtaposed both studies, drawing linkages and allusions to commonalties between them. This, as Wilsford notes, provides greater insight into the relationship between the independent and dependent variables in each case. Moreover, an explicitly comparative method will help distinguish between the culturally specific factors and those more general which are part of the explanation.

This is a study which is primarily concerned with politics and the political. As such, it considers what shapes policy among the various interests and actors that face-off against each other within national political systems. Because of this concern this study and its method is essentially qualitative rather than quantitative, it is more interested in discourse than in numbers. As Wilsford notes, "Quantitative studies, of course, are essential to the demonstration of aggregate relationships, but they contribute less to contextual knowledge" (1991, p. 5). Although this study considers a number of issues related to health system reform, it is politics writ large which limits or facilitates this process. These "often fall outside the capabilities of quantification" (Wilsford, 1991, p. 5).

The first task of comparative research is to determine the differences or similarities among polities, institutions or agents - once again emphasizing the fact that

comparative research need not be cross-national research. Determining these differences or similarities requires conceptualization. A concept must be clearly defined and strong enough to survive its use across nations and cultures. In other words, it is essential to develop questions which travel. This can be done by using variables that measure the same concept across space, time and cultures or using concepts that are specific to each case and then comparing these among units in the comparative set (Rose, 1988, p. 220; Bahry, 1981, p. 231; see also Sartori, 1970).

In this study, measuring the influence of the New Right on government policy required a mix of both common and country-specific concepts. The preponderance of neoliberal ideas in the 1980s across the West made the comparison of the discourses of the British and Canadian governments possible, but part of the analysis had to be rooted in the different traditions of conservatism in both countries. Thus, my approach was to combine cross-national and single case variables.

In selecting which cases to study one must also keep in mind whether one is looking for differences or similarities. Comparative research involves generally two strategies, either a *most-similar* or *most-different* systems design (Bahry 1981, p. 231). In short, if one chooses to compare systems considered similar, then any finding of difference invalidates the similarities between systems as the explanatory variable. My study used a *most-different* systems approach where I expected the differences between Canada's federal system and Britain's unitary system to be a significant explanatory variable. Although this was not entirely confirmed by my findings, differences in political system did prove to have an impact on the outcome of New Right policies.

The contextual material presented in this study is from two main sources, primary documents and research interviews. The research process therefore mirrored that described by Dunleavy and Rhodes (1990, p. 5),

> Cross referencing published documentation, mass media coverage and participant interviews may not give fully authoritative accounts but they produce more insights than the prevailing reliance on memoirs, diaries and platitudinous observations by ex-ministers.

In total 24 research interviews were conducted, nine in the UK and sixteen in Canada. The interviews were useful in evaluating the politics of the period, particularly in terms of the factors driving or hampering policy. Documentary materials were used in evaluating and describing these policies. In terms of overall balance this research leans most on documentary evidence rather than on interview material. The major part of this research was conducted over a period of eighteen months, with the remaining time spent writing the text of this dissertation. Some additional research among secondary and tertiary sources was done in the course of putting the final touches to the dissertation.

The first part of this research - conducted between October 1993 and July 1994 - was taken up in tertiary source research on both Canada and Britain as well as preliminary readings on the theoretical aspects of the research process. In the closing months of this phase it was decided that field work in Canada would be conducted in the summer of 1994. As a result tertiary source research focused more closely on the Canadian half of this study.[1]

The field work in Canada took place between July and September 1994 and focused generally on secondary and primary source research. For this part of the study a series of research interviews were arranged with representatives of the Canadian and

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[1] Although more attention was placed on the Canadian case at this point a conference paper in April 1994 comparing both Canada and Britain in the health field provided an opportunity to continue to consult British sources.

provincial governments and health interest groups.[2] During this period primary source research was conducted focusing primarily on parliamentary debates and reports and government documents. In some instances interviewees were able to provide additional documentation that was used in the course of this study. A related development was suggestions made by some interviewees as to other individuals who could be contacted for additional information. The material collected during this field work was synthesized and written up in two versions. The first, collating and cross referencing interview material, was completed in October 1994 and mailed to all persons interviewed for their comments.[3] The second version, which took note of the comments received, was completed in December 1994.[4]

The British research mirrored the process conducted previously. Representatives of interest groups and government were interviewed between March and July 1995. As was the case during the Canadian field work, primary sources (primarily parliamentary and governmental documents) were also researched during this period. The results of this research were written up in chapter form and sent to interviewees for their comments in July 1995. Their responses were taken into consideration in the final writing of the British chapters.

It is following the conclusion of the case research that consideration was given to anchoring the theoretical themes raised by the research questions to particular writers in the field.[5] These frameworks were then married to the case material in the course of writing the conclusion and rewriting the substantive chapters of this study.

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2 See bibliography for the list of interviews conducted and their dates and places.
3 A single follow-up interview was conducted in Canada in June 1995.
4 An additional Canadian source interview was conducted in January 1995.
5 This was partially necessitated by a change in supervision in August 1995.

In the course of this research programme a number of methodological problems were encountered. Initially it proved extremely difficult to obtain recent material on health policy and politics in Canada. This problem was mostly offset by the Canadian fieldwork but explains the uneven period of time spent on each case study.

A more pressing problem proved to be accessing primary source material, particularly British sources. As was to be the case in the course of the interview programme, much of this difficulty I ascribe to differences in the respective political cultures of Canada and Britain. The Canadian tradition of "Open Government," epitomized in the federal *Access to Information* legislation, meant that documents were both freely available and provided at no charge. Access to government department libraries was unrestricted and photocopying on site was also free of charge. This permitted the researcher to gather a large quantity of both primary and material. Letter inquiries to provincial governments yielded even more documentary material - most of which could not find a place within this thesis. This generosity also extended to representatives of many of the interest groups interviewed.

Access to British documentation was more difficult to achieve. Beyond command papers, parliamentary debates and legislation, which are available in HMSO shops and libraries, no 'unofficial' document was made available for this research. Moreover, requests for additional documentation from persons interviewed for the British segment of this research yielded only few documents and all of these were from the interest group sector.

This situation was mirrored in the course of the interview process. Senior Canadian government representatives, interest group representatives and former politicians agreed to be interviewed. Although not all the persons who accepted to

participate in interviews were subsequently contacted due to time restraints, overall only two outright refusals were received as a result of letters of inquiry.[6]

The selection for Canadian interviews was made according to criteria establishing the relevance of the organization, its place in the health field or the position held by the individual which provided them with a particular insight on the issue. Government of Canada and provincial government representatives were selected based upon information in their respective governmental phone books[7] or specialist directories[8] - documents which are available in most public libraries in Canada. The same procedure was utilized in selecting the representatives of interest groups. In some instances the persons interviewed declined to participate due to their recent promotion to their post but gratefully arranged interviews with persons within their departments with the expertise to answer my questions.[9] However, this points to one of the problems encountered. While ostensibly non-political posts, Assistant Deputy Ministers and Deputy Ministers are shuffled regularly in accordance with the prevailing political wind. As the interviews were conducted approximately eight to twelve months after a change in government and, moreover, following a major overhaul of the federal government's administrative machinery in June 1993, some of the persons interviewed in the senior ranks had only a few months in their current position. However, due to their wider experience at these

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[6] The only group which had to be missed during the interview process was the Royal College of Physicians of Canada due to their late acceptance of the interview request. Other individuals contacted but subsequently not interviewed were the Deputy Ministers of Health of British Columbia and Prince Edward Island. The only groups to refuse to be interviewed were the Canadian Chamber of Commerce and the Canadian Council for Social Development. The Business Council on National Issues for its part only accepted to participate in a short phone interview.

[7] The Government of Canada phone directory is a particularly useful research tool as it is updated every six months. It lists by department every civil servant, their specific post and their relevant section, their address, phone and fax number. Such a tool made it easy to distinguish among individuals of similar 'grades' but whose field of concern within the same departments were quite different.

[8] Such as the Corpus Administrative Index which is published every year and provides the up-to-date name and particulars of senior government officials across Canada.

[9] This was the case for example with personal interview CDN 5.

levels in other departments and the inevitable paper trails left by their predecessors these interviews, following cross referencing with other interviews and other sources, were nonetheless judged to be informative.[10] In the interest group sector only one organization had undergone a change in leadership since the period of my study[11] and in one instance the interest group representative was a former senior federal official, thereby providing greater insight into the decision making process of the Mulroney Tories.[12] Unfortunately it was not possible to track down all the officials who had occupied senior positions during the period covered by this research. Sixteen interviews were conducted in Canada, and all were treated confidentially. In addition two academics were consulted in order to seek their views and guidance[13] during the course of the Canadian field work.

The British interviews proved much more difficult to arrange. Although geographic proximity allowed a larger number of interview requests to be made in Britain (21) than in Canada (19), the response rate was much lower.[14] In the end only nine research interviews were conducted in Britain. These interview contacts were made in a manner similar to that utilized in Canada, that is using government and association directories.[15] Although fewer interviews were done, many of the British interviewees had long term knowledge of the 1979-1990 period which proved most useful. While the Whitehall tradition of secrecy was difficult to circumvent, these interviews permitted the

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10 This was the case for example with personal interview CDN 9.

11 Personal interview CDN 10.

12 Personal interview CDN 16.

13 Donald Swartz (Carleton University) and Antonia Maioni (McGill).

14 It is believed that the response rate was probably influenced by circumstances affecting the health community during the period, particularly a party leadership battle and a nurses pay dispute. However, I remain perplexed by the large number of 'non-responses' to invitation letters.

15 As a directory of Whitehall is not publicly available the British government contacts were made using the much less informative Civil Service Yearbook.

cross referencing of primary and secondary material. As in the Canadian case all interviews in Britain were treated confidentially.

Finally, although much is made above of the interview process, the majority of this research was spent utilizing the resources of several public and governmental libraries. It is primarily in these that my stamina and spirit as a researcher was tested and without the access to these resources the arguments presented in this thesis would have little foundation.

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Personal interview CDN 5: Senior official, Health Canada.

Personal interview CDN 6: Representative, Business Council on National Issues.

Personal interview CDN 7: Senior official, Nova Scotia Department of Health.

Personal interview CDN 8: Senior assistant, Office of the Minister of Health Canada Diane Marleau.

Personal interview CDN 9: Assistant Deputy Minister, Health Canada.

Personal interview CDN 10: Senior official, Canadian Health Coalition.

Personal interview CDN 11: Senior official, Canadian Nurses Asociation.

Personal interview CDN 12: Senior official, Canadian College of Health Service Executives.

Personal interview CDN 13: Assistant Deputy Minister, Department of Finance Canada.

Personal interview CDN 14: Assistant Deputy Minister, Ontario Ministry of Health.

Personal interview CDN 15: Assistant Deputy Minister, Ministère de la Sante et des Services sociaux, Governement du Québec.

Personal interview CDN 16: Senior representative, Canadian Medical Association.

Personal interview GB 1: Senior official, British Medical Association.

Personal interview GB 2: Health policy analyst.

Personal interview GB 3: Senior official, Association of Community Health Councils of England and Wales.

Personal interview GB 4: Senior official, UK Department of Health.

Personal interview GB 5: Former senior official, UK Department of Health.

Personal interview GB 6: Representative, Royal College of General Practitionners.

Personal interview GB 7: Former senior official, NHSME.

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Personal interview CDN 1: Former federal Minister of Health and Welfare.

Personal interview CDN 2: Former Ontario Minister of Health.

Personal interview CDN 3: Assistant Deputy Minister, Ministère de la Sante et des Services sociaux, Governement du Québec.

Personal interview CDN 4: Senior official, Canadian Hospital Association.

Personal interview CDN 5: Senior official, Health Canada.

Personal interview CDN 6: Representative, Business Council on National Issues.

Personal interview CDN 7: Senior official, Nova Scotia Department of Health.

Personal interview CDN 8: Senior assistant, Office of the Minister of Health Canada Diane Marleau.

Personal interview CDN 9: Assistant Deputy Minister, Health Canada.

Personal interview CDN 10: Senior official, Canadian Health Coalition.

Personal interview CDN 11: Senior official, Canadian Nurses Asociation.

Personal interview CDN 12: Senior official, Canadian College of Health Service Executives.

Personal interview CDN 13: Assistant Deputy Minister, Department of Finance Canada.

Personal interview CDN 14: Assistant Deputy Minister, Ontario Ministry of Health.

Personal interview CDN 15: Assistant Deputy Minister, Ministère de la Sante et des Services sociaux, Governement du Québec.

Personal interview CDN 16: Senior representative, Canadian Medical Association.

Personal interview GB 1: Senior official, British Medical Association.

Personal interview GB 2: Health policy analyst.

Personal interview GB 3: Senior official, Association of Community Health Councils of England and Wales.

Personal interview GB 4: Senior official, UK Department of Health.

Personal interview GB 5: Former senior official, UK Department of Health.

Personal interview GB 6: Representative, Royal College of General Practitionners.

Personal interview GB 7: Former senior official, NHSME.

Personal interview GB 8: Senior official, Public Health Alliance.

Personal interview GB 9: Representative, COHSE/UNISON.

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